

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #9 Film #G388 4/25/67 pc

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05272

05270

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRINGS</b>				c. LENGTH OF STAY IN 1b <b>DOA</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HOLY CROSS HOSPITAL</b>				d. STREET ADDRESS <b>4704 ASPEN HILL ROAD</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>STANLEY RAYMOND ACKERMAN</b>				4. DATE OF DEATH Month Day Year <b>APRIL 15 19 67</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUC</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN 27, 1934</b>		9. AGE (In years last birthday) <b>33 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>US NAVY</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>COZAD, NEBR.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>JOHN R. ACKERMAN</b>				14. MOTHER'S MAIDEN NAME <b>LELIA HALVERSTADT</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>507 36 0383</b>		17. INFORMANT <b>MARIANNE T. ACKERMAN</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction, Acute</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>4401</b> (c)				INTERVAL BETWEEN ONSET AND DEATH <b>3 hr.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John. S. Ball</b> M.D.				22. DATE SIGNED <b>4/16/67</b>			
EXAMINER'S NAME (Type) <b>JOHN G. BALL MD</b>				23a. REC'D BY REGISTRAR <b>Charles Judge</b>			
23b. DATE THEREOF <b>4/17/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>UNKNOWN</b>		23d. LOCATION (City or Town) (County) (State) <b>COZAD NEBR.</b>		23e. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
24. FUNERAL DIRECTOR <b>W.W. CHAMBERS Co - Washington, DC.</b>				DATE <b>APR 20 1967</b>			

MEDICAL CERTIFICATION

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*John A. Hall*

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## CERTIFICATE OF DEATH

05271

Reg. Dist. No.

05273

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>5133 Broad Branch Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Esther</u> Middle <u>May</u> Last <u>Albertson</u>		4. DATE OF DEATH Month <u>4</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 12, 1901</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Theodore Pollak</u>		14. MOTHER'S MAIDEN NAME <u>Annie Work</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>230-50-1254</u>	
17. INFORMANT <u>James Albertson - Son</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction extensive</u> DUE TO <u>Coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary arteriosclerosis</u> (c) <u>Coronary arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>48</u> , to <u>24 April</u> , 19 <u>67</u> , that I last saw the deceased alive on <u>24 April</u> , 19 <u>67</u> , and that death occurred at <u>7:03 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John M. Wyman</u>		ADDRESS (Street, city or town, state) <u>7801 Norfolk Ave.</u>	
PHYSICIAN'S NAME (Type) <u>JOHN M. WYMAN</u>		DATE SIGNED <u>4-25-67</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-28-67</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>APR 28 1967</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the funeral director, and the registrar should be filed with the registrar.

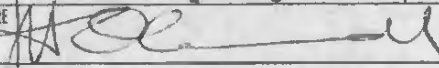
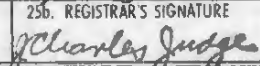




05274

## CERTIFICATE OF DEATH

05272

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>California</b> b. COUNTY <b>Rolling Hills Estates</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>			c. LENGTH OF STAY IN 1b <b>4 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rolling Hills Estates</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>				d. STREET ADDRESS <b>5256 Willow Wood</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Alton</b> Middle <b>S.</b> Last <b>ALLBRITTON</b>				4. DATE OF DEATH Month <b>April</b> Day <b>3</b> Year <b>1967</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cauc.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 5, 1914</b>	
9. AGE (In years last birthday) <b>52</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Navy (Ret'd)</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Arcadia, Florida</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William C. Allbritton</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II Korea -1958</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Rolling Hills Estates, Calif.</b> <b>Mrs. Tolona Allbritton, 5256 Willow Wood</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>4</del> (this hospital) attended the deceased from <b>March 30</b> , 19 <b>67</b> , to <b>April 3</b> , 19 <b>67</b> that <del>1</del> (we) last saw the deceased alive on <b>April 3</b> , 19 <b>67</b> , and that death occurred at <b>1250 PM</b> from causes and on the date stated above.							
22a. SIGNATURE 				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>April 4, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>F. H. O'CONNELL, M.D.</b>				22d. ADDRESS <b>Naval Hospital, Bethesda, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 5-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR <b>Simmons Brothers Funeral Home</b> <b>1661 Good Hope Road, S. E., Washington, D.C.</b>				25a. REC'D BY REGISTRAR <b>APR 6 1967</b>		25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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## CERTIFICATE OF DEATH

05273

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>District of Columbia</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>19 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hosp. of Silver Spring</u>		e. STREET ADDRESS <u>2100 Connecticut Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Samuel R. Amato</u>		4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/4/1906</u>
9. AGE (In years last birthday) yrs. <u>67</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner Business</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>PARKING LOT</u>		11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>IGNATIUS AMATO</u>	
14. MOTHER'S MAIDEN NAME <u>ROSA DECRISTINA</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>577-05-7747</u>		17. INFORMANT <u>GRACE B. AMATO - SEE ITEM #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Colon</u> DUE TO 1538 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 1966, to <u>4/24</u> , 1967, that (I) (we) last saw the deceased alive on <u>4/23</u> , 1967, and that death occurred at <u>3:00 A.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>G. Lennard Gold</u>		22b. DATE SIGNED <u>4/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. Lennard Gold, M.D.</u>		22d. ADDRESS <u>8641 Colesville Rd., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>4-29-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Bethel, Vermont</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>APR 26 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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APR 2 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05276

CERTIFICATE OF DEATH

05274

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b> c. LENGTH OF STAY IN 1b <b>1 Day</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> <b>Virginia</b> b. COUNTY <b>Norfolk</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Kenneth McArthur Andrews Jr.</b>			4. DATE OF DEATH Month <b>April</b> Day <b>29</b> Year <b>19 67</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 11, 1967</b>	9. AGE (In years lost birthday) yrs. <b>18</b>	IF UNDER 1 YEAR Months <b>18</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Portsmouth, Virginia</b>			
13. FATHER'S NAME <b>Kenneth McArthur Andrews</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Sandra Leigh Brown</b> <b>9632 Atlans Street</b> <b>Kenneth M. Andrews Norfolk, Va.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>7545 CONGENITAL HEART DISEASE</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>Apr. 29</b> , 19 <b>67</b> , to <b>Apr. 29</b> , 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>Apr. 29</b> , 19 <b>67</b> , and that death occurred at <b>8:40 P.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>T.E. Kelly</b> 22c. PHYSICIAN'S NAME (Type) <b>T.E. KELLY MD</b>			22b. DATE SIGNED <b>30 APRIL 1967</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			
<b>Burial - Transit 5-1-67</b>				<b>Indian Branch Cem.</b>			
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY BETHESDA, MARYLAND</b> <b>BELK-KING FUNERAL HOME, DARLINGTON, S.C.</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 3 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



05234

05234

Virginia

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1948-1949

(1948-1949)

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1959-1960

1959-1960

1960-1961

1961-1962

# FOR STATE HEALTH-DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

<div>Item 18 Film 388 5-8-67 a MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div>													
05277						MEDICAL EXAMINER'S CERTIFICATE OF DEATH						05275	
1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>D. O. A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Silver Spring Forest Glen Rd.</u>						d. STREET ADDRESS <u>2803 Landonown Way</u>							
3 NAME OF DECEASED (Type or print) <u>Walter J. Andrews</u>						4 DATE OF DEATH <u>April 22 1967</u>							
5 SEX <u>M</u>		6 COLOR OR RACE <u>W</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>2-18-06</u>		9 AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>12</u>		IF UNDER 24 HRS Hours <u>12</u> Min <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Best mfg.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Office Supply Equipment</u>				11. BIRTHPLACE (State or foreign country) <u>Wash DC</u>				12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>HARRY R. ANDREWS</u>						14 MOTHER'S MAIDEN NAME <u>MARY FANCH</u>							
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes give year or dates of service</u>				16 SOCIAL SECURITY NO <u>577-09-5471</u>		17 INFORMANT <u>KATH ANDREWS - 411 E. S. 1st St. Silver Spring</u>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial &amp; congestive ht. failure</u> DUE TO <u>201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Acute myocardial occlusion</u> DUE TO (c) <u>Coronary sclerosis, severe</u>										INTERVAL BETWEEN ONSET AND DEATH <u>15-20 min</u> <u>15-20 min</u> <u>Yrs.</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>										19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>John S. Rogers</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) <u>John S. Rogers</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
22. DATE SIGNED <u>4-22-67</u>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
23a. BURN, CREMATION, REMOVAL (Specify) <u>Autopsy</u>						23b. DATE THEREOF <u>Apr 25, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Chesapeake Beach, Md.</u>			
24. FUNERAL DIRECTOR <u>John B. Thomas</u>						25a. REC'D BY REGISTRAR <u>APR 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #9 Film #G 87 477/67 DC

CERTIFICATE OF DEATH

05278		05276	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>WASH. D.C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	c. LENGTH OF STAY IN 1b <u>2 weeks</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NORTH WEST</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Sanitarium</u>		d. STREET ADDRESS <u>1435 Chapin. ST</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>M.</u> Last <u>Anderson</u>		4. DATE OF DEATH Month <u>4</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/27/1873</u>
9. AGE (In years last birthday) <u>93 9/4 yrs</u>		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>19</u> Hours <u>67</u> Min	
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PATENT ATTORNEY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LAW</u>	
11. BIRTHPLACE (County & State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edward W. Anderson</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH F MASI</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO <u>579-52-9584</u>	
17. INFORMANT <u>MANNEVILLETT SULLIVAN</u>		Address <u>4600 MASS AVENUE NW WASH DC.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ARTERIO-SCLEROTIC HEART DISEASE</u> DUE TO <u>WITH HEART FAILURE</u> (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO <u>SENILITY</u> (c) <u>PROSTATIC HYPERTROPHY</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 MONTHS</u> <u>20 YRS</u> <u>2 YRS</u> <u>10 YRS</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>NONE</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NO</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 6, 1963</u> , to <u>3/22/67</u> , that (I) (we) last saw the deceased alive on <u>3/22/1967</u> , and that death occurred at <u>5 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Reamur S. Donnelly</u>		22b. DATE SIGNED <u>4/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Reamur S. Donnelly MD</u>		22d. ADDRESS <u>1827 23 RD ST NW WASH DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>4-3-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT OLIVET CEM</u>	23d. LOCATION (City or Town) (County) (State) <u>BLADENSBURG MD</u>
24. FUNERAL DIRECTOR <u>W.W. Chambers Co</u>		25a. REC'D BY REGISTRAR <u>APR 4 1967</u>	
ADDRESS <u>1400 Chapin St N.W.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05273

CERTIFICATE OF DEATH

05277

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>735 Sligo Avenue</i>		d. STREET ADDRESS <i>735 Sligo Avenue</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Josephine Klein Asmus</i>		4. DATE OF DEATH Month Day Year <i>April 10 1967</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Caucasian</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar 2, 1893</i>
9. AGE (In years last birthday) <i>74 yrs</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>New Jersey</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Michael Klein</i>		14. MOTHER'S MAIDEN NAME <i>Caroline Dietjen</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No None</i>		16. SOCIAL SECURITY NO. <i>Yes</i>	
17. INFORMANT <i>Grover E. Asmus</i>		Address <i>735 Sligo Avenue Silver Spring, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO <i>Congestive heart failure</i> (b) <i>Cor pulmonale</i> DUE TO <i>Pulmonary emphysema</i> (c)			INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs.</i> <i>15 yrs.</i>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <i>Jan</i> , 19 <i>64</i> , to <i>April 10, 1967</i> , that (1) (we) last saw the deceased alive on <i>Mar. 31, 1967</i> , and that death occurred at <i>5:15</i> P.M., from causes and on the date stated above.			
22a. SIGNATURE <i>James R. Coleman M.D.</i>		22b. DATE SIGNED <i>4/10/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>James R. Coleman, M.D.</i>		22d. ADDRESS <i>9341 Columbia Blvd., Silver Spring, Md.</i>	
23a. BURIAL-CREATION, REMOVAL (Specify) <i>Trans-burial</i>	23b. DATE THEREOF <i>Apr. 14, 1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Flower Hill Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>North Bergen, New Jersey</i>
24. FUNERAL DIRECTOR <i>Glen Carter Collins Co., 8434 Georgia Ave. Silver Spring, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>APR 17 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

MEDICAL CERTIFICATION

Cleared by Medical Examiner - B. Rep. Ms. James Coleman

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

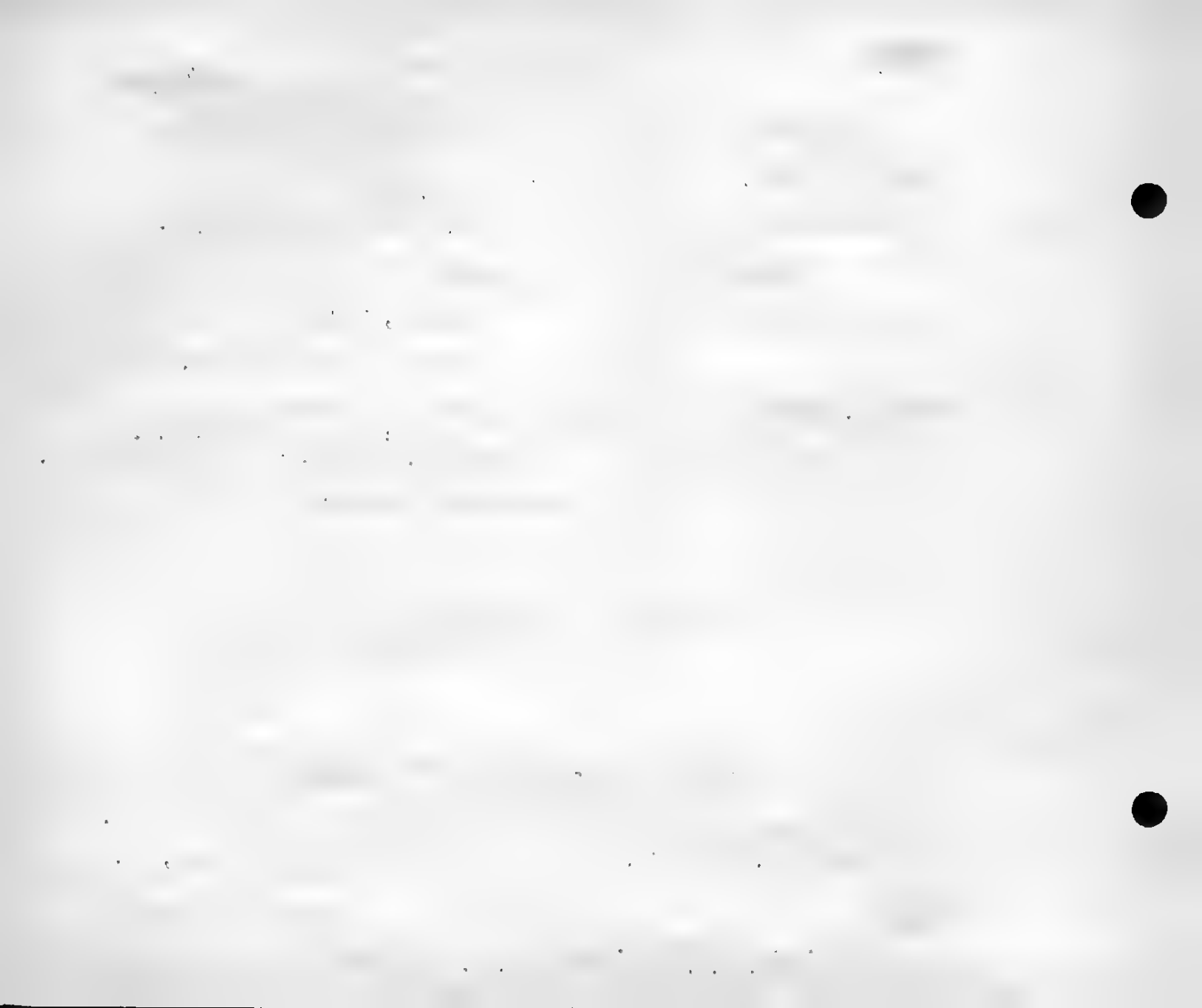
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

35280

CERTIFICATE OF DEATH

05278

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>DISTRICT OF COLUMBIA</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA (RURAL)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b>	
c. LENGTH OF STAY IN 1b <b>3 HRS 16 MIN</b>		d. STREET ADDRESS <b>APT: 301 5038 LIVINGSTON TERRACE, S.E.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>NAVAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ELEANA BANDONG</b>		4. DATE OF DEATH Month Day Year <b>APRIL 14 1967</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>MALAYSIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 14, 1967</b>
9. AGE (In years last birthday) yrs		10. IF UNDER 1 YEAR Months Days Hours Min <b>24</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NA</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NA</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>BETHESDA, MONTGOMERY, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>RUDOLFO Q. BANDONG</b>		14. MOTHER'S MAIDEN NAME <b>MARIA SARMIENTO</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NA NA</b>		16. SOCIAL SECURITY NO <b>NA</b>	
17. INFORMANT <b>APT: 301 WASHINGTON, D.C. RUDOLFO Q. BANDONG, 5038 LIVINGSTON TERR.S.E.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive pulmonary atelectasis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>APRIL 14, 1967</b> , to <b>APRIL 14, 1967</b> , that (I) (we) last saw the deceased alive on <b>APRIL 14, 1967</b> , and that death occurred at <b>0420AM</b> , from causes and on the date stated above			
22a. SIGNATURE <i>Jerry J. Tomasovic</i> MD		22b. DATE SIGNED <b>14 Apr. 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Jerry J. Tomasovic, MD</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>4/18/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>	23d. LOCATION (City or Town) (County) (State) <b>ARLINGTON, VIRGINIA</b>
24. FUNERAL DIRECTOR <b>W. W. CHAMBERS CO.</b>		25a. REC'D BY REGISTRAR <b>DATE APR 18 1967</b>	25b. REGISTRAR'S SIGNATURE <i>James Judge</i>
<b>1400 CHAPIN STREET, N.W., WASHINGTON, D. C.</b>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

05281

05279

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>Don't know</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>117833 Cliffbourne Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Joseph</u> First Middle Last <u>Bannon</u>		4. DATE OF DEATH <u>4-2-67</u> Month Day Year	
5. SEX <u>m</u>	6. COLOR OR RACE <u>gr</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 10, 1967</u> 2mo. 12
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>John J. Bannon</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Haass</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Father-John J. Bannon</u>		Address <u>Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Bronchopneumonia, bilateral, interstitial type</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>hours</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	23b. DATE THEREOF <u>4/5/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Rose</u>	23d. LOCATION (City or Town) (County) (State) <u>Gaithersburg, Md.</u>
24. FUNERAL DIRECTOR <u>Ernest C. Gartner</u>		25a. REC'D BY REGISTRAR <u>APR 7 1967</u>	
Address <u>Gaithersburg, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





05282

CERTIFICATE OF DEATH

05280

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. LENGTH OF STAY IN TB <u>13 hrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>1607 GRANDIN AVE</u>			
3. NAME OF DECEASED (Type or print) First <u>CLARENCE</u> Middle <u>E</u> Last <u>BARDSLEY</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>25</u> Year <u>1967</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-23-94</u>	
				9. AGE (In years at birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.C.D.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>St. Louis, Miss</u>	
13. FATHER'S NAME <u>Edward Bardsley</u>				14. MOTHER'S MAIDEN NAME <u>Isabella Greig</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>173-20-3701</u>		17. INFORMANT Address <u>Luth A. Bardsley - e - above - life</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331A Intracerebral Hemorrhage, right, spontaneous</u> DUE TO (b) <u>Rupture right middle cerebral artery</u> DUE TO (c) <u>Advanced cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 days</u> <u>years</u>	
						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Heart Disease</u>	
						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Aug., 1960</u> to <u>April 24, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 24, 1967</u> , and that death occurred at <u>12:30 M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>G. Bowditch Hunter, Jr.</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>April 25, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. Bowditch Hunter, Jr.</u>				22d. ADDRESS <u>50 W. Edmonston Drive, Rockville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/29/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rolla Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rolla, Missouri</u>	
24. FUNERAL DIRECTOR <u>Tycoon Heeler Funeral Home, 131 Rockville Pike, Rockville, Md.</u>				25a. REC'D BY REGISTRAR <u>APR 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



05283

## CERTIFICATE OF DEATH

05281

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>9 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>5528 Johnson Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Morris</u> <u>Karlynn</u> <u>Barrett</u>		4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>18 August 1900</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>months</u> Hours <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Medicine</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>J. Morris Barrett</u>		14. MOTHER'S MAIDEN NAME <u>Thomasann Payne</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WW I &amp; II</u>		16. SOCIAL SECURITY NO <u>216-44-6818</u>	
17. INFORMANT <u>The Medical Record</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u> DUE TO <u>1621</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) _____ DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>28 March</u> , 19 <u>67</u> , to <u>6 April</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>6 April</u> , 19 <u>67</u> , and that death occurred at <u>6:25 M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Martin H. Cohen</u>		22b. DATE SIGNED <u>7 April 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Martin H. Cohen, M.D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>APR. 8, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>CEAR HILL CREMATORY</u>		23d. LOCATION (City or Town) (County) (State) <u>SU. FLAND, MARYLAND</u>	
24. FUNERAL DIRECTOR <u>JOS. GAULER'S SONS, INC. WASHINGTON, D.C.</u>		25a. REC'D BY REGISTRAR <u>APR 12 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial or transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

05284

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05282

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. LENGTH OF STAY IN Ia <b>ADELPHI</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON SAN. &amp; HOSP.</b>		d. STREET ADDRESS <b>1818 METZEROTT</b>	
3 NAME OF DECEASED (Type or print) <b>LORRAINE GARNETT BARRY</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>24</b> Year <b>1967</b>	
5 SEX <b>FEMALE</b>	6 CO. OR OR RACE <b>WHITE</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>7-1-23</b>
9 AGE (In years last birthday) <b>43</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USLA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <b>D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>AMER.</b>	
13. FATHER'S NAME <b>MARTWELL SMITH</b>		14. MOTHER'S MAIDEN NAME <b>MARY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16 SOCIAL SECURITY NO.	
17 INFORMANT <b>ELAINE BARRY, AS ABOVE (DTR.)</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Acute, severe, fatty metamorphosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>of liver</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Belden R. Keap</b> M.D.		22. DATE SIGNED <b>4/24/1967</b>	
EXAMINER'S NAME (Type) <b>BELDEN R. KEAP, M.D.</b>		DEPUTY MEDICAL EXAMINER <b>Charles Judge</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>4/28/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Prince Georges County, Md</b>	
24. FUNERAL DIRECTOR <b>The S.H. Hines Company</b> <b>2901 14th St. N.W. Washington, D.C.</b>		25a. REC'D BY REGISTRAR <b>APR 26 1967</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05285

CERTIFICATE OF DEATH

05283

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>37 Mins</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>McLean</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>				d. STREET ADDRESS <b>1244 Titania Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>Leid</b> Last <b>Beardsley</b>				4. DATE OF DEATH Month <b>April</b> Day <b>8</b> Year <b>19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7 July 1914</b>		9. AGE (In years lost birthday) <b>52</b> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>US Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ACTIVE DUTY</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Louisiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Harold Beardsley</b>				14. MOTHER'S MAIDEN NAME <b>Helen Gantt</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>038 26 0576</b>		17. INFORMANT <b>Mrs. Virginia M. Beardsley</b> Address <b>McLean, Va. 1244 Titania Lane</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <b>8 April</b> 19 <b>67</b> , and that death occurred at <b>0637</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Jack E. Zimmerman</b> M.D.				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>4/9/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Jack E. Zimmerman</b>				22d. ADDRESS <b>USNH, Bethesda, Md. 20014</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/10/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Va.</b>	
24. FUNERAL DIRECTOR <b>W. W. Chambers</b>				ADDRESS <b>1400 Chapin St. NW, WDC</b>		25a. REC'D BY REGISTRAR <b>APR 11 1967</b>	
						25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>New York</u> b. COUNTY <u>Westchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Steven</u> First Middle <u>Matthew</u> Last		4. DATE OF DEATH Month <u>4</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR & RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 25 1939</u> 27 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Steven Benkovich</u>		14. MOTHER'S MAIDEN NAME <u>Anna Straub</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>Marines</u>		16. SOCIAL SECURITY NO <u>127-30-5536</u>	
17. INFORMANT <u>Brother</u>		Address <u>Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONTUSION HEART</u> DUE TO <u>Automobile Accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Automobile Accident</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRINCIPAL OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18.) <u>Driving Car Crashed into Auto Crossing Highway at Intersection</u>	
20c. TIME OF INJURY Month, Day, Year <u>4:15 p.m. 4/8 1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u> Chevy Chase Montgomery Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <u>4/9/67</u>	
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-11-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>	23d. LOCATION (City or town) (County) (State) <u>Valhalla N.Y.</u>
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Md</u>		25a. REC'D BY REGISTRAR <u>APR 13 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>W. Charles Judge</u>	



FOR STATE  
HEALTH DEPT.

05287

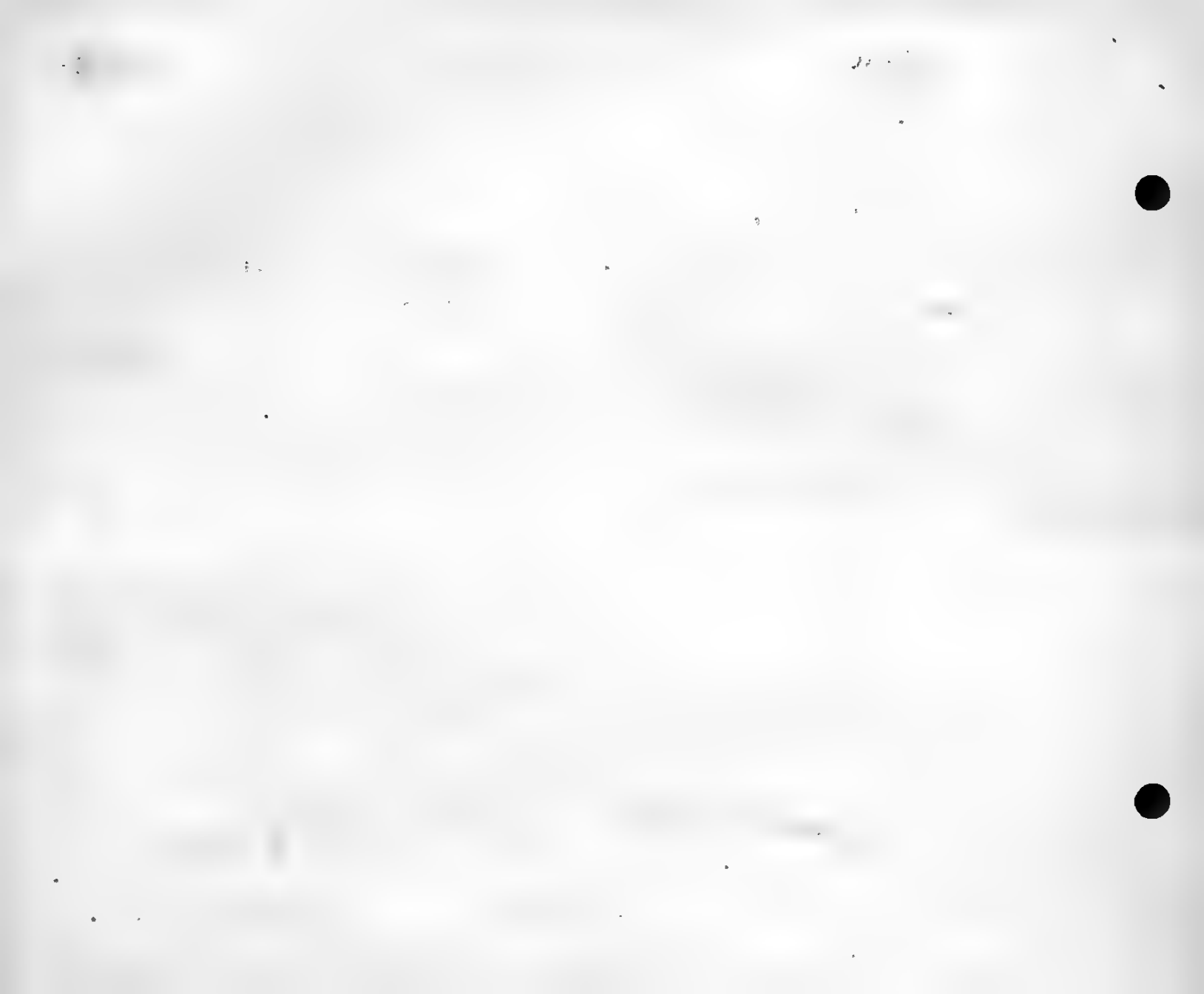
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05288

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7107 Connecticut Ave.</u>		d. STREET ADDRESS <u>7107 Connecticut Ave.</u>	
3 NAME OF DECEASED (Type or print) <u>Pauline N. Benton</u>		4 DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/23/31</u>
9 AGE (In years last birthday) <u>36</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Biochemist</u>	
11. BIRTHPLACE (State or foreign country) <u>Minnesota</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Victor Moll</u>		14 MOTHER'S MAIDEN NAME <u>Rachel - M. Perkins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Duane A. Benton</u>		Address <u>Same as Item 2.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Popping - Barbiturate poisoning</u> DUE TO (b) <u>overdose of Tuinal and alcohol</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hr. ?</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Took overdose of Tuinal and alcohol</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>2:30</u> a.m. <u>4</u> p.m. <u>16</u> <u>67</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Cherry Chase Montg. Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		22. DATE SIGNED <u>4/16/67</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		Address (Street, city, town or county) <u>Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-19-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>APR 24 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05288

05289

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b> c. LENGTH OF STAY IN 1b <b>WASH. D.C.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON D.C.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASH. D.C.</b> d. STREET ADDRESS <b>1660 PARK RD. N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LAURA HENRY BLACK</b> First Middle Last		4. DATE OF DEATH Month Day Year <b>APRIL 28 1967</b>	
5. SEX <b>FE.</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-22-76</b> 9. AGE (In years last birthday) <b>90 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during usual of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>	
13. FATHER'S NAME <b>WILLIAM STETSON</b>		14. MOTHER'S MAIDEN NAME <b>VICTORIA ROBERTS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>CHART</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Disease, Curved fibrillation</b> 4222 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension, hypertrophy, related to</b> DUE TO (c) <b>ja</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>4/27/1967</b> to <b>4/28/1967</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>11</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Wesley Holston</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Wesley Holston</b>		22d. ADDRESS <b>7461 1/2 Ave Rd NW</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>5/2/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>	23d. LOCATION (City or town) (County) (State) <b>Prince Georges County, Md</b>
24. FUNERAL DIRECTOR <b>St. Johns Co 3901 14th NW DC</b>		25a. REC'D BY REGISTRAR <b>MAY 1 1967</b> 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

Medical Certification  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

05288

05284

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>4005 Lawrence Ave</u>	
3 NAME OF DECEASED (Type or print) <u>Kate Copeland Bloomer</u>		4 DATE OF DEATH Month <u>April</u> Day <u>27</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/16/1886</u>
9. AGE (In years last birthday) <u>80</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Benjamin Copeland Seaton</u>		14. MOTHER'S MAIDEN NAME <u>Jane Gilbert</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>William J. Bloomer Jr. - Son</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>C coronary Arteriosclerosis &amp; Thrombosis</u> DUE TO (c) <u>  </u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Apr. 6, 1967</u> to <u>Apr 27, 1967</u> that (I) (we) last saw the deceased alive on <u>Apr 26, 1967</u> and that death occurred at <u>7:22</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Robert T. Thibadeau</u>		22b. DATE SIGNED <u>Apr 27-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert T. Thibadeau</u>		22d. ADDRESS <u>Rockville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Apr 29, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>
24. FUNERAL DIRECTOR <u>Glen Carter</u>		25a. REC'D BY REGISTRAR <u>MAY 1 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. ADDRESS <u>4844 Georgia Avenue Silver Spring, Md.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05290

CERTIFICATE OF DEATH

05285

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
c. LENGTH OF STAY IN 1b <u>26 days</u>		d. STREET ADDRESS <u>8231 14th Ave. Apt 201</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>MAX</u> Middle <u>Louis</u> Last <u>BLUM</u>		4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-11-94</u>
9. AGE (Years last birthday) <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Govt General Services Administration</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Gerson Blum</u>		14. MOTHER'S MAIDEN NAME <u>Dora Marcus</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>577-24-7185</u>	
17. INFORMANT <u>Medical Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Leukemia, lymphocytic, acute</u> DUE TO (b) <u>2 years</u> DUE TO (c) <u>Interval between onset and death</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cardio-vascular disease, congestive heart failure</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3-20</u> , 1967, to <u>4-15</u> , 1967, that (I) (we) last saw the deceased alive on <u>4-15</u> , 1967, and that death occurred at <u>7:25</u> p.m., from causes and on the date stated above.			
22a. SIGNATURE <u>Eino Magi</u>		22b. DATE SIGNED <u>4-15-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>		22d. ADDRESS <u>831 University Blvd. E. Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-17-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>King David Mon.</u>	23d. LOCATION (City or town) (County) (State) <u>Falls Church Virginia</u>
24. FUNERAL DIRECTOR <u>Goldberg Funeral Home</u>		25a. REC'D BY REGISTRAR <u>APR 18 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

05291

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05286

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>12617 Epping Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Abraham</u> First Middle Last		4. DATE OF DEATH <u>April 6</u> 19 <u>67</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-13-89</u> 79 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of work ing life, even if retired) <u>SELF EMPLOYED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FUEL OIL</u>	
11. BIRTHPLACE (State or foreign country) <u>Russian</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SOLO J. BOCAR</u>		14. MOTHER'S MAIDEN NAME <u>MICHELE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>577-56-8508A</u>	
17. INFORMANT <u>daughter Sarah (Jagur)</u> Address <u>He 9-4028</u>			
18. CAUSE OF DEATH (Enter on any cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Coronary Insufficiency Acute</u> (b) <u>Cardio Vascular Disease</u> DUE TO <u>years</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> MD		22. DATE SIGNED <u>April 6, 1967</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>4-7-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GEO. WASH. CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>HYATTSVILLE MD</u>
24. FUNERAL DIRECTOR <u>GOEDBERG FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>421797NS.UW</u> DATE <u>APR 10 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





05292

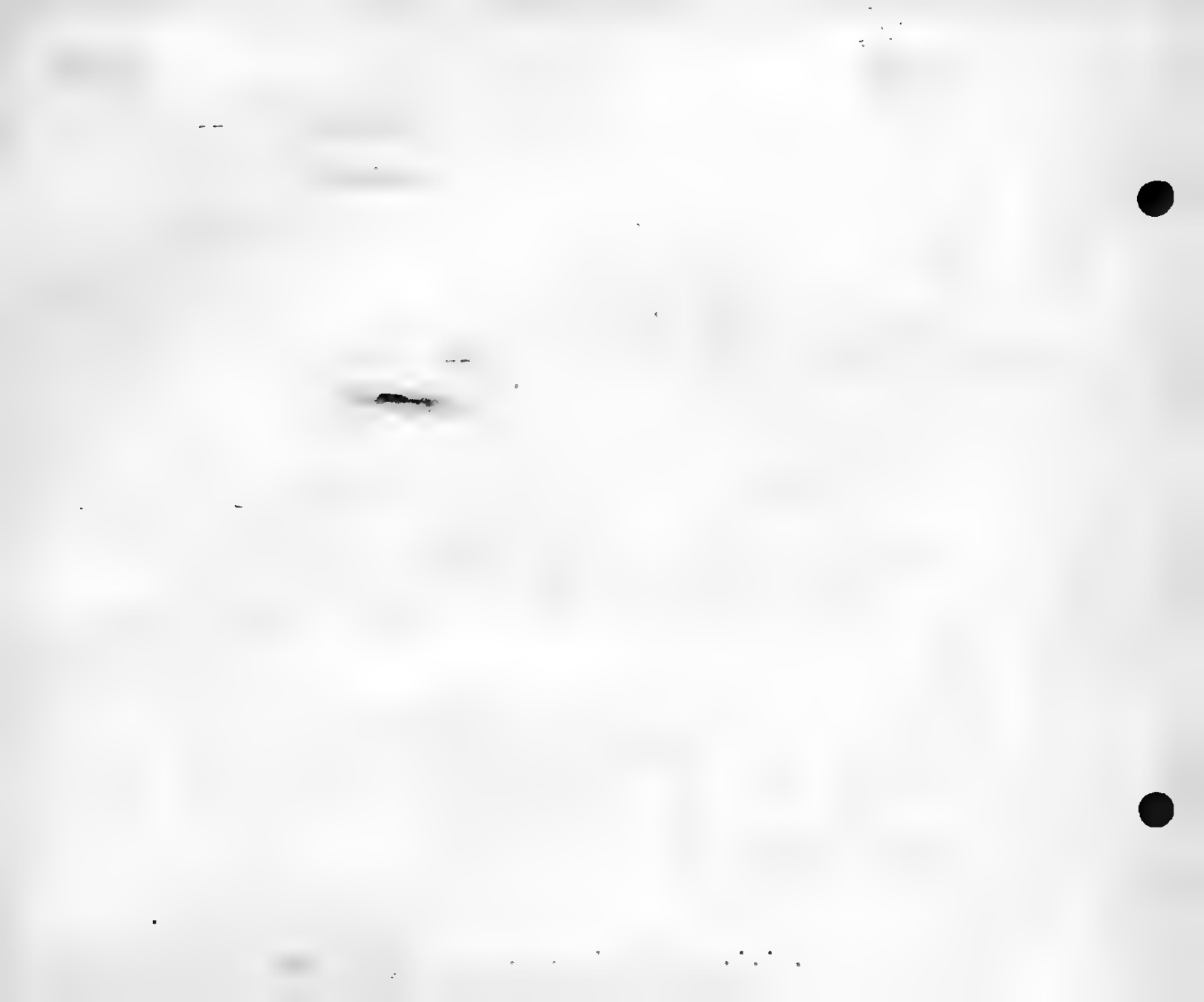
## CERTIFICATE OF DEATH

05290

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN IB <u>Wyattsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>FAIRLAND NRSG HOME 2101 FAIRLAND ROAD</u>		d. STREET ADDRESS <u>2214 Calvert Street</u>	
3 NAME OF DECEASED (Type or print) <u>FRANK BREITWIESER</u>		4 DATE OF DEATH Month <u>APRIL</u> Day <u>10</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-17-1892</u>
9. AGE (In years lost birthday) <u>75 yrs</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BUSINESSMAN Retired</u>	
11. RTHPLACE (County & State, or foreign country) <u>HUNGARY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>PHILIP BREITWIESER</u>		14. MOTHER'S MAIDEN NAME <u>Salome Dickenschiedt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-10-4321</u>	
17. INFORMANT <u>Katherine Soule same as #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, Heart Failure</u> DUE TO (b) <u>Metastatic Ca of Prostate</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>9 mos</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>66</u> , to <u>Apr 10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Mar 26</u> , 19 <u>67</u> , and that death occurred at <u>11:45</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>James J. Foster</u>		22b. DATE SIGNED <u>4/10/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>James J. Foster</u>		22d. ADDRESS <u>1746 K St NW Wash. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>4/13/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Md.</u>
24. FUNERAL DIRECTOR <u>The S. H. Hines Co.</u>		25a. REC'D BY REGISTRAR <u>APR 13 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REGISTRAR'S NAME <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05293

## CERTIFICATE OF DEATH

05291

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
c. LENGTH OF STAY IN IB <b>17 Days</b>		d. STREET ADDRESS <b>5400 Pooks Hill Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Bethesda Silver Spring Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>EDA BOSE BREWER</b>		4. DATE OF DEATH Month Day Year <b>April 27, 19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 14, 1892</b>
9. AGE (In years lost birthday) yrs <b>74</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Herman Bose</b>		14. MOTHER'S MAIDEN NAME <b>Ida Beuhler</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-20-1568</b>	
17. INFORMANT <b>Son</b>		<b>7405 Ridgeway Ave</b>	
<b>Scott R. Brewer, Jr. - Chevy Chase, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pseudo-fulbar Palsy</b> <b>507A</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>cerebral arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> <b>3 or more years</b>	
PART II OTHER SIGNIFKANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>August, 1962</b> to <b>April 27, 1967</b> that (I) (we) last saw the deceased alive on <b>April 26, 1967</b> , and that death occurred at <b>6:05 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Robert N. Coale</b>		22b. DATE SIGNED <b>April 27, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT N. COALE</b>		22d. ADDRESS <b>4429 Bradley Lane, Chevy Chase Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5-1-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Natl Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>MAY 3 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

05292		05292	
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sylvan Manor Health Care Center</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> d. STREET ADDRESS <b>318 - Lincoln Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARY EVERETT BRIGGS</b>		4. DATE OF DEATH <b>APR 18 1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 11 - 1891</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Willie Vireo Everett</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ella Freed</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Nursing Home Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS</b> DUE TO (b) <b>CARCINOMA</b> DUE TO (c) <b>BREAST</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>DEC. 21, 1966</b> to <b>APR. 18, 1967</b> , that (I) (we) last saw the deceased alive on <b>APR. 18, 1967</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert T. Thibadeau</b>		22b. DATE SIGNED <b>APR 18 - 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT T. THIBADEAU</b>		22d. ADDRESS <b>ROCKVILLE MD 20852</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>April 20 - 1967</b>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <b>Leo Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Spink Road, Md</b>	
24. FUNERAL DIRECTOR <b>Arthur Walters</b>		25a. REC'D BY REGISTRAR <b>APR 21 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



05295

## CERTIFICATE OF DEATH

05293

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>160 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>		d. STREET ADDRESS <u>Box #44</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Yvonne Patricia Briscoe</u>		4. DATE OF DEATH Month Day Year <u>April 2 19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>13 September 1944</u>
9. AGE (In years lost birthday) <u>22</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James A. Briscoe</u>		14. MOTHER'S MAIDEN NAME <u>Carolyn Bowman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>The Medical Record</u>		Address <u>The Clinical Center, Bethesda, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gram Negative Septicemia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Leukemia</u> DUE TO (c) <u>Unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>1 Hour</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (a) (this hospital) attended the deceased from <u>Oct. 24, 1966</u> , to <u>April 2, 1967</u> , that (b) (we) last saw the deceased alive on <u>April 2, 1967</u> , and that death occurred at <u>2:25 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>William R. Lewis</u>		22b. DATE SIGNED <u>3 April 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>William R. Lewis</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>APRIL 5, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. JOSEPH'S</u>	23d. LOCATION (City or Town) (County) (State) <u>MORGANZA, ST. MARY'S, MD.</u>
24. FUNERAL DIRECTOR <u>W. CLARKE MATTINGLEY</u>		25a. REC'D BY REGISTRAR <u>APR 10 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. ADDRESS <u>LEONARDTOWN, MARYLAND</u>	





05296

## CERTIFICATE OF DEATH

05294

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Prince George's</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. &amp; Hosp.</u>		d STREET ADDRESS <u>3420 Chatham Road</u>	
3 NAME OF DECEASED (Type or print) <u>Jessie Eulala Burke</u>		4 DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>6-25-92</u>
9a AGE (In years last birthday) yrs <u>74</u>		9b IF UNDER 1 YEAR Months <u>13</u> Days <u>19</u> Hours <u>67</u> Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Joel Fulton</u>		14 MOTHER'S MAIDEN NAME <u>Martha Vaughn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.	
17 INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Renal failure &amp; Uremia</u> Interval BETWEEN ONSET AND DEATH <u>Several days</u>			
DUE TO (b) <u>Metastatic Carcinoma from gas Bladder</u> <u>1 yr (Est)</u>			
DUE TO (c) <u>Cholelithiasis</u> <u>3 yrs</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour <u>am</u> <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>1963</u> , 19 <u>  </u> , to <u>4/13</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/13</u> , 19 <u>67</u> , and that death occurred at <u>  </u> M, from causes and on the date stated above.			
22a SIGNATURE <u>Raymond O West</u>		22b DATE SIGNED <u>April 13, 1967</u>	
22c PHYSICIAN'S NAME (Type) <u>Raymond O West</u>		22d ADDRESS <u>Silver Springs, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>April 16, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Kernersville Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Kernersville Forsyth N C</u>
24 FUNERAL DIRECTOR <u>F. Gaschs Sons Hyattsville, Md</u>		25a REC'D BY REGISTRAR DATE <u>APR 17 1967</u>	25b REGISTRAR'S SIGNATURE <u>Charles Juerga</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



05297

## CERTIFICATE OF DEATH

05295

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Damascus</b>		c. LENGTH OF STAY IN 1b <b>Damascus</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>26730 Ridge Rd.</b>		d. STREET ADDRESS <b>26730 Ridge Rd.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Laura Gertrude Burns</b>		4. DATE OF DEATH Month Day Year <b>April 15 19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 17, 1873</b>
9. AGE (In years last birthday) yrs. <b>94</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>15</b>	
10a. USULA OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Purdim, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward King</b>		14. MOTHER'S MAIDEN NAME <b>Julia Burdette</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs Aubrey Mullineaux, Item 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>15 years</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>2/10</b> , 19 <b>58</b> to <b>4/15</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>4/11</b> , 19 <b>67</b> , and that death occurred at <b>2:30 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>James P. Kerr</b>		22b. DATE SIGNED <b>4/16/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>James P. Kerr, M.D.</b>		22d. ADDRESS <b>Damascus, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Apr. 17, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. View</b>	23d. LOCATION (City or Town) (County) (State) <b>Purdim, Md.</b>
24. FUNERAL DIRECTOR <b>Olin L. Molesworth, Damascus, Md.</b>		25a. REG. BY REGISTRAR <b>APR 19 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles J. Moore</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

35293

05296

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Mass.</u> b. COUNTY <u>SUFFOLK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda D.C.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hedge Park - Boston</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>87 Wingate Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Francis Joseph Cameron</u>				4. DATE OF DEATH Month <u>4</u> Day <u>22</u> Year <u>1967</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-16-95</u>	
9. AGE (In years, months and days) <u>71</u>		10. UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>		11. BIRTHPLACE (State or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - draftsman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Postal Sr.</u>			
13. FATHER'S NAME <u>Thomas Cameron</u>				14. MOTHER'S MAIDEN NAME <u>Mary Finnegan</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>026-18-7393</u>			
17. INFORMANT <u>SON</u> Address <u>4403 Chestnut St.</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO <u>Chronic Myocardial Disease</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (b) <u>17 years</u> (c) <u>17 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22. ACTUAL SIGNATURE <u>John S. Rogers</u> M.D.				22. DATE SIGNED <u>4-22-67</u>			
EXAMINER'S NAME (Type) <u>John S. Rogers M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>4-24-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Swedish Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Worcester, Mass</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR <u>APR 28 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



05299

CERTIFICATE OF DEATH

05297

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. LENGTH OF STAY IN 16 <b>42 days</b>	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Washington, D. C.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium and Hospital</b>			d. STREET ADDRESS <b>1211 Kalnia Road, N. W.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Genevieve Elizabeth Carr</b>		4. DATE OF DEATH Month Day Year <b>April 24 19 67</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 27, 1907</b>	9. AGE (In years last birthday) <b>60 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min. <b>24 19 67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Frank P. Carr</b>		14. MOTHER'S MAIDEN NAME <b>Betsy G. Saffell</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-28-6017</b>		17. INFORMANT <b>Mrs. Frank Carr</b> Address <b>1211 Kalnia Road, N.W. Washington, D. C.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4541</b> <b>TERMINAL PULMONARY EDEMA</b> DUE TO (b) <b>Congestive Heart Failure</b> DUE TO (c) <b>Congenital Heart disease</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 mos.</b> <b>Life</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>1-28</b> , 19 <b>67</b> , to <b>4/23</b> , 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>4/23</b> , 19 <b>67</b> , and that death occurred at <b>2:20 AM</b> , from causes and on the date stated above.						
22a. SIGNATURE <b>Francis X. Richardson</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/24/67</b>		
22c. PHYSICIAN'S NAME (Type) <b>Francis X. Richardson, M. D.</b>		22d. ADDRESS <b>11412 Viers Mill Road, Wheaton, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr 26, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		
23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>		24. FUNERAL DIRECTOR <b>Warner E. Humphrey, Inc.</b> Address <b>8434 Georgia Avenue Silver Spring, Md.</b>				
25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





05300

CERTIFICATE OF DEATH

05298

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN TB <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>10500 Old Georgetown Rd</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Samuel E. Cartw</u> First Middle Last				4. DATE OF DEATH <u>April 20</u> 19 <u>67</u> Month Day Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/7/09</u> 9. AGE (In years last birthday) <u>57</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Hocoe Cartw</u>				14. MOTHER'S MAIDEN NAME <u>Bessie</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>57-41-5226</u>		17. INFORMANT <u>Wife Geraldene</u> (Same as above) Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>atherosclerosis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Essential Hypertension</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1963</u> , 19 <u>to 4-20</u> , 19 <u>67</u> , that (I) <u>we</u> lost saw the deceased alive on <u>4-20</u> 19 <u>67</u> , and that death occurred at <u>1:10</u> M, from causes and on the date stated above							
22a. SIGNATURE <u>Donald L Bucy</u> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>4-20-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>DONALD L BUCY</u>				22d. ADDRESS <u>809 Veirs Mill Rd Rockville Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>4/22/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		23d. LOCATION (City or Town) (County) (State) <u>Bethesda, Maryland</u>	
24. FUNERAL DIRECTOR <u>Myron Healer Funeral Home</u> ADDRESS <u>111 Rock Pike Rockville, Md.</u>				25a. REC'D BY REGISTRAR <u>APR 24 1967</u> DATE		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

VR A15 (4)  
20 M 1/66

1  
M  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #2b,c & d File 328 5/8/67  
05301  
05299  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Heaton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> <u>Balto.</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>4608 Roland Ave</u> <u>11701 6th Ave Wheaton, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Wheaton Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY ROBERTA Chase</u>		4. DATE OF DEATH <u>April 27 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-2-18 66</u>
9. AGE (In years last birthday) <u>100 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) <u>Pennsylvania</u>	
13. FATHER'S NAME <u>William Jefferis Barnes</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Anna Beans</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>5325 Adelbert Rd. Washington, D. C.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary occlusion</u> DUE TO (b) <u>Senile Generalized Arteriosclerosis</u> DUE TO (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma Vulva</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>—</u> 19 <u>—</u> p.m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-17</u> , 19 <u>67</u> , to <u>4-27</u> , 19 <u>67</u> that (I) ( <u>we</u> ) last saw the deceased alive on <u>4-26</u> 19 <u>67</u> , and that death occurred at <u>9:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>P. P. Andrews</u>		22b. DATE SIGNED <u>4-27-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>P. P. ANDREWS M.D.</u>		22d. ADDRESS <u>WASHINGTON, D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/1/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Friends Burial Grounds</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Wm. J. Tichner &amp; Sons</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>MAY 1 1967</u>	



## CERTIFICATE OF DEATH

05302

05300

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Tennessee</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>			c. LENGTH OF STAY IN 1b <b>4 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Memphis</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>				d. STREET ADDRESS <b>3986 Weaver Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Calvin M. CHAVIES</b>				4. DATE OF DEATH Month <b>April</b> Day <b>11</b> Year <b>19 67</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Cauc</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 12, 1912</b>	
9. AGE (In years last birthday) yrs. <b>54</b>		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>11</b> Hours <b>19</b> Min.		11. BIRTHPLACE (County & State, or foreign country) <b>Unknown Dawson Springs, Ky.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Unknown Dawson Springs, Ky.</b>	
13. FATHER'S NAME <b>Unknown Calvin Hunsaker</b>				14. MOTHER'S MAIDEN NAME <b>Unknown Rose Ferrell</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO <b>- - -</b>		17. INFORMANT <b>Memphis</b> Address <b>Tennessee</b> <b>Mr. Edward J. Chavies, 3986 Weaver Road</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarct</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Rheumatic aortic stenosis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>April 7, 1967</b> , to <b>April 11, 1967</b> , that (we) last saw the deceased alive on <b>April 11, 1967</b> , and that death occurred at <b>8:15 A.M.</b> , from causes and on the date stated above.							
22a. SIGNATURE <i>David R. Foreman</i>				22b. DATE SIGNED <b>Apr. 13, 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>David R. FOREMAN, M. D.</b>	
22d. ADDRESS <b>Naval Hospital, Bethesda, Maryland</b>				22e. REC'D BY REGISTRAR <b>APR 20 1967</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-14-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D. C.</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler &amp; Sons</b> ADDRESS <b>5130 Wisconsin Ave., Washington, D. C.</b>				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05303

05301

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Wash. San + Hospital</u>		d. STREET ADDRESS <u>7603 - 15th ave.</u>	
3. NAME OF DECEASED (Type or print) <u>James Taylor Chewning</u>		4. DATE OF DEATH Month <u>4</u> Day <u>15</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-17-46</u>
9. AGE (In years last birthday) <u>20</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk at G.P.O.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Govt. Printing Off. D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lester M. Chewning</u>		14. MOTHER'S MAIDEN NAME <u>Mary Wynkoop</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>Yes</u>	
17. INFORMANT <u>Lester Chewning</u>		18. ADDRESS <u>7603 15th Avenue Takoma Park, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MULTIPLE INJURIES, SEVERE</u> DUE TO (b) <u>TRAUMA FROM AUTO ACCIDENT</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <u>Passenger in car, went out of control struck pole</u>	
20c. TIME OF INJURY Month, Day Year <u>1:30 p.m. 4/15 1967</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> <u>Highway</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Adelphi Prince Georges Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
ADDRESS <u>7936 Old Georgetown Rd. Bethesda, Maryland</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>4/15/67</u>	
22. DATE SIGNED		23a. BIRTHAL CREMATION REMOVAL (Specify) <u>Burial</u>	
23b. DATE THEREOF <u>Apr. 19, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	
23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>		24. FUNERAL DIRECTOR <u>Warner E. Purphrey, Inc. Silver Spring, Md.</u>	
25. REC'D BY REGISTRAR <u>APR 18 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. ...</u>	

100





05304

## CERTIFICATE OF DEATH

05302

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCKVILLE</b> c. LENGTH OF STAY IN 1b <b>2 months</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Potomac Valley Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) a. STATE <b>CALIFORNIA</b> b. COUNTY <b>SUNLAND</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>7948 Wentworth Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MERCELIA</b> First Middle Last <b>CHINO</b>		4. DATE OF DEATH Month Day Year <b>April 28 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 9, 1888</b> 9. AGE (In years last birthday) <b>78 yrs</b> IF UNDER 1 YEAR Months Days Hours Mins
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State or foreign country) <b>Missouri</b>
13. FATHER'S NAME <b>Thomas F. Hicks</b>		14. MOTHER'S MAIDEN NAME <b>Tda E. Scofield</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <b>325-09-5392</b>	17. INFORMANT <b>Elbert Chino (son)</b> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>SEPTICEMIA</b> DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>CEREBROVASCULAR ACCIDENT</b> DUE TO (c) <b>ARTERIOSCLEROSIS GENERAL</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 DAYS</b> <b>4 1/2 MRS</b> <b>20 YRS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>2/26/67</b> , 19__ to <b>4/28/67</b> , 19__, that (I) (we) last saw the deceased alive on <b>4/24/67</b> , 19__, and that death occurred at <b>8:45</b> M, from causes and on the date stated above			
22a. SIGNATURE <i>Ronald L. Barr</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) <b>RONALD L. BARR, M.D.</b>		22d. ADDRESS <b>10401 OLD GERRIETOWN RD BETHESDA, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>4/28/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematorium</b>	23d. LOCATION (City or Town) (County) (State) <b>Washington D. C.</b>
24. FUNERAL DIRECTOR <b>Lee Funeral Home</b>		25a. REC'D BY REGISTRAR <b>MAY 1 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash San &amp; Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>1374 Taylor St. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Antonio Chite</u>						4. DATE OF DEATH Month <u>4</u> Day <u>3</u> Year <u>1967</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-7-83</u>		9. AGE (In years and months) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>19</u> Hours <u>67</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>				11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Carmelo Chite</u>						14. MOTHER'S MAIDEN NAME <u>Carmela</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO <u>577-48-0896</u>		17. INFORMANT <u>Hospital Record.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute bronchopneumonia, Bilateral</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I): 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Belden R. Keap</u> M.D.						22. DATE SIGNED <u>April 3, 1967</u>					
EXAMINER'S NAME (Type) <u>BELDEN R. KEAP, M.D.</u>						DEPUTY MEDICAL EXAMINER <u>Charles Judge</u> Address (Street, City, Town, or County)					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>4-3-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Washington, D.C.</u>			
24. FUNERAL DIRECTOR <u>Francis J. Collins</u> Address <u>3821-14th St. NW WashDC</u>						25a. REC'D BY REGISTRAR DATE <u>APR 7 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



Cleared to medical examiner.

Dr. Reap.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05306

## CERTIFICATE OF DEATH

05304

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tahoma Park</u>		c. LENGTH OF STAY IN 1b <u>2 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>				d. STREET ADDRESS <u>923 Langley Drive</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bertha</u> <u>May</u> <u>FORD Clark</u>				4. DATE OF DEATH Month Day Year <u>4</u> <u>24</u> <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-17-93</u>	9. AGE (In years last birthday) <u>73</u> yrs	IF UNDER 1 Year Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>South Dakota</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Ford</u>				14. MOTHER'S MAIDEN NAME <u>Adelma Dunn</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>578-10-9651D</u>		17. INFORMANT <u>Records - Washington Sanitarium &amp; Hospital</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Extensive carcinoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. _____ 19____	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>October</u> , 19 <u>66</u> , to <u>April 24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>April 24</u> , 19 <u>67</u> , and that death occurred at <u>4:55 p.m.</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>John N. Andrews</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>Apr. 24-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John N. Andrews</u>				22d. ADDRESS <u>9601 Colleville Rd Silver Spring Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>4/28/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>			
24. FUNERAL DIRECTOR <u>The S. H. Hines Co. 2901-14th St D.C.</u>				25a. REC'D BY REGISTRAR DATE <u>APR 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Phonias Judge</u>	

MEDICAL CERTIFICATION



05307

## CERTIFICATE OF DEATH

05305

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>DIST. OF COL.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>8700 Jones Mill Road</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bethesda-Silver Spring Nurs. Home</u>		d. STREET ADDRESS <u>4421 Hawthorne St. N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Kathryn Jones Clark</u>		4. DATE OF DEATH Month <u>4</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-15-87</u>
9. AGE (In years last birthday) yrs <u>90</u>		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Jersey City</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert Jones</u>		14. MOTHER'S MAIDEN NAME <u>Anna Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>G. Edward Clark (son)</u>		Address <u>See Item #2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO (b) <u>4200</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>---</u> DUE TO (c) <u>---</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>---</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan.</u> , 19 <u>66</u> , to <u>4/9</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>4/9</u> , 19 <u>67</u> , and that death occurred at <u>9:00</u> A.M., from causes and on the date stated above.			
22a. SIGNATURE <u>G. Leonard Gold</u>		22b. DATE SIGNED <u>4/9/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. Leonard Gold</u>		22d. ADDRESS <u>8641-Colesville Rd. Silver Sp. Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>4-12-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Brick Church Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Montgomery, N.Y.</u>
24. FUNERAL DIRECTOR <u>Gawler's</u>		25a. REC'D BY REGISTRAR <u>Wash. J.C.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>APR 12 1967</u>	





05308

## CERTIFICATE OF DEATH

05308

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>	
c. LENGTH OF STAY IN 1b <u>6 mo - 20 da.</u>		d. STREET ADDRESS <u>104 Cedar ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>POTOMAC VALLEY NURSING HOME</u> <u>POTOMAC VALLEY R.O.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARGUERITE N. CLEMENTS</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 7-1890</u>
9. AGE (In years last birthday) yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>cl</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Fry, Mich.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Sidal Miles</u>		14. MOTHER'S MAIDEN NAME <u>Alice B. Foorie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Wm. John P. Griffith</u>		Address <u>Gaithersburg</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral thrombosis</u> DUE TO (b) <u>cerebral atherosclerosis</u> DUE TO (c) <u>stoking the underlying cause lost.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9-19</u> , 19 <u>63</u> , to <u>4-7</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>3-14</u> , 19 <u>62</u> , and that death occurred at <u>10:30</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>D. L. Bucy / SN Jones</u>		22b. DATE SIGNED <u>4-7-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>D. L. Bucy - SN JONES</u>		22d. ADDRESS <u>809 Veirs Mill Rd Rockville Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u>	23b. DATE THEREOF <u>4-10-76</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>	23d. LOCATION (City or town) (County) (State) <u>Gaithersburg Montg. Md.</u>
24. FUNERAL DIRECTOR <u>Ernest C. Gartner</u>		25a. REC'D BY REG. STRAR <u>APR 10 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>William Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

35309

CERTIFICATE OF DEATH

05307

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>20 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>		d. STREET ADDRESS <u>8105 Eastern Avenue</u>	
3 NAME OF DECEASED (Type or print) <u>Bertram Jay Cohen</u>		4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 25, 1942</u>
9 AGE (In years last birthday) <u>24 yrs</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Interviewer</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Jack Cohen</u>		14. MOTHER'S MAIDEN NAME <u>Florence Waxman</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>216-40-7826</u>	
17. INFORMANT <u>The Medical Record</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO (b) <u>Lymphosarcoma</u> DUE TO (c) <u>lost.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>40 minutes</u>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour or p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (a) (this hospital) attended the deceased from <u>April 9</u> , 1967, to <u>April 29</u> , 1967, that (a) (we) last saw the deceased alive on <u>April 29</u> 1967, and that death occurred at <u>11:40M</u> , from causes and on the date stated above.			
22a SIGNATURE <u>Leonard H. Brubaker</u> M.D.		22b DATE SIGNED <u>April 30, 1967</u>	
22c PHYSICIAN'S NAME (Type) <u>Leonard H. Brubaker, M.D.</u>		22d ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b DATE THEREOF <u>4/30/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>King David Mem. Gar.</u>	23d LOCATION (City or Town) (County) (State) <u>Falls Ch., Virginia</u>
24 FUNERAL DIRECTOR <u>Bernard Danzansky &amp; Sons</u>		25a REC'D BY REGISTRAR <u>10 MAY 2 1967</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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05310

## CERTIFICATE OF DEATH

05308

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA (rural)</b> c. LENGTH OF STAY IN 1b <b>NAVAL HOSPITAL</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>VIRGINIA</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ALEXANDRIA</b> d. STREET ADDRESS <b>1108 PALMER PLACE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>VINCENT</b> First <b>WILLIAM</b> Middle <b>COLLINS</b> Last		4. DATE OF DEATH <b>APRIL</b> Month <b>21</b> Day <b>19</b> Year <b>67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUC</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6 MAY 1967</b> 9. AGE (In years last birthday) <b>45</b> yrs IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>US NAVY</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>LYNCHBURG, VA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>EDWARD RANDOLPH COLLINS</b>		14. MOTHER'S MAIDEN NAME <b>ELLA WILLIAMS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES</b> <b>Active</b>		16. SOCIAL SECURITY NO. <b>229 03 3421</b>	
17. INFORMANT <b>CAROL M. COLLINS</b>		Address <b>1108 PALMER PLACE ALEXANDRIA, VIRGINIA</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>21 APRIL, 1967</b> , to <b>21 APRIL, 1967</b> , that (I) (we) last saw the deceased alive on <b>21 APRIL, 1967</b> , and that death occurred at <b>5:40 AM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>H. RIVAS</b>		22b. DATE SIGNED <b>21 APRIL 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>H. RIVAS</b>		22d. ADDRESS <b>NAVAL HOSPITAL</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>4/24/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>PINE CREST GARDENS</b>	23d. LOCATION (City or town) (County) (State) <b>MARIANNA, FLORIDA</b>
24. FUNERAL DIRECTOR <b>W.E. CHAMBERS CO.</b> 1400 CHAPIN ST. NW WASHINGTON, DEC.		25a. REC'D BY REGISTRAR <b>APR 25 1967</b> DATE	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05311

CERTIFICATE OF DEATH

05309

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>GERMANTOWN Rt #2</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Potomac Valley Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <i>Clara P. Connable</i>		4. DATE OF DEATH Month <i>April</i> Day <i>6</i> Year <i>1967</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 22, 1880</i>
9. AGE (In years last birthday) <i>87 yrs.</i>		10. IF UNDER 1 YEAR Months <i>1</i> Days <i>10</i> Hours <i>20</i> Min	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		11b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	
12. BIRTHPLACE (County & State, or foreign country) <i>Chicago, Illinois</i>		13. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
14. FATHER'S NAME <i>Frank Patterson</i>		15. MOTHER'S MAIDEN NAME <i>Annie Ryan</i>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		17. SOCIAL SECURITY NO <i>219 54 5206T</i>	
18. INFORMANT <i>Margaret G. Riggs - Daughter - same</i>		Address	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Uremia</i> DUE TO <i>Sclerotic nephritis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>Arterio Sclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>78 days</i> <i>10 yrs</i> <i>20 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Obstructive jaundice</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>30 March, 1967</i> to <i>6 April, 1967</i> that (I) (we) last saw the deceased alive on <i>5 April 1967</i> , and that death occurred at <i>6:00 AM</i> , from causes and on the date stated above			
22a. SIGNATURE <i>William S. Murphy</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>William S. Murphy</i>		22d. ADDRESS <i>615 N. Montgomery Ave., Rockville, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	23b. DATE THEREOF <i>4/6/67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>	23d. LOCATION (City or town) (County) (State) <i>Prince George, Maryland</i>
24. FUNERAL DIRECTOR <i>Tyson Heeler Funeral Home</i>		25a. REC'D BY REGISTRAR <i>APR 7 1967</i>	
ADDRESS <i>1341 Rock. Pike Rockville, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05312

CERTIFICATE OF DEATH

05310

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Essex</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. LENGTH OF STAY IN lb <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kensington Gardes Nursing Home</b>		d. STREET ADDRESS <b>130 G.A. Windsor Mill Road</b>	
3. NAME OF DECEASED (Type or print) <b>Margory Ann Contant</b>		4. DATE OF DEATH Month <b>April</b> Day <b>21</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 27, 1903</b>
9. AGE (In years last birthday) <b>63</b> yrs.		10. IF UNDER 24 HRS Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard Stack</b>		14. MOTHER'S MAIDEN NAME <b>Frances Patton</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Diabetes mellitus</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			19. INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 18</b> , 19 <b>66</b> to <b>April 21</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>April 21</b> , 19 <b>67</b> , and that death occurred at <b>5:20 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>H F Kreuzburg</b>		22b. DATE SIGNED <b>4/21/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>H F Kreuzburg</b>		22d. ADDRESS <b>7852 16th NW Wash DC</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>April 22, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Suitland Md.</b>
24. FUNERAL DIRECTOR <b>Robert E. Wilhelm Funeral Home 4308 Suitland</b>		25a. REC'D BY REGISTRAR <b>APR 25 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CLEARED WITH MEDICAL EXAMINER *A. Trauer* / *6 M*

VR A15 (4)  
20 M 1/66

05313

CERTIFICATE OF DEATH

05311

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission). a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Georges</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c LENGTH OF STAY IN 1b <b>1-1/2 hrs.</b>	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>W. Hyattsville</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		d. STREET ADDRESS <b>5601 Parkerhouse Terr</b>	e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) <b>Robert NMI Contino</b>		4. DATE OF DEATH Month <b>4</b> Day <b>2</b> Year <b>1967</b>	
5 SEX <b>M</b>	6 COLOR OR RACE <b>W</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Feb 26, 1897</b>
9 AGE (In years last b rthday) <b>70 yrs</b>		10 IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11 IF UNDER 24 HRS Hours <b>0</b> Min <b>0</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Timekeeper</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Hotels</b>	11 BIRTHPLACE (County & State, or foreign country) <b>Brooklyn, N.Y.</b>
12 CITIZEN OF WHAT COUNTRY? <b>USA.</b>		13 FATHER'S NAME <b>Unknown</b>	
14 MOTHER'S MAIDEN NAME <b>Unknown</b>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes WWI - Army</b>	
16 SOCIAL SECURITY NO <b>577 26 8283</b>		17 INFORMANT <b>wife/Sylvia Contino</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary artery insufficiency</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Known 1 yr</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>	
20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	
20f (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>1966</b> to <b>April 2, 1967</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>April 2, 1967</b> , and that death occurred at <b>4:45 P.M.</b> from causes and on the date stated above.	
22a. SIGNATURE <b>Arnon H. Trauer</b>		22b. DATE SIGNED <b>April 2, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>ARON H. TRAUER M.D.</b>		22d. ADDRESS <b>8237 Georgia Ave - Silver Spring, Maryland</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr 7, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Alexandria National Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Alexandria, Virginia</b>	
24 FUNERAL DIRECTOR <b>John B. Thomas &amp; Sons, Inc.</b>		25a REC'D BY REGISTRAR <b>APR 7 1967</b>	
25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c ADDRESS <b>8434 Georgia Avenue Silver Spring, Md.</b>	



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05314

05312

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kenwood</b> c. LENGTH OF STAY IN b		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kenwood</b> d. STREET ADDRESS <b>5415 Dorset Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ma</b> Middle <b>Sibson</b> Last <b>Cooper</b>		4. DATE OF DEATH Month <b>4</b> Day <b>4</b> Year <b>1967</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 6, 1884</b>	9. AGE (In years last birthday) <b>83</b> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Kansas</b>	
13. FATHER'S NAME <b>Robert J. Gibson</b>		14. MOTHER'S MAIDEN NAME <b>Ella Banks</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-52-2208</b>		17. INFORMANT <b>Son Kenneth B. Cooper</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Cardio Vascular Disease</b> 4281 Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) DUE TO DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20. Forest La, N.W. Washington, D. C.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1964</b> to <b>4-4</b> , 1967 that (I) (we) last saw the deceased alive on <b>4-3</b> , 1967, and that death occurred at <b>8 A.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Geo. R. Huffman</b> 22c. PHYSICIAN'S NAME (Type) <b>GEORGE R. HUFFMAN</b>		22b. DATE SIGNED <b>Apr. 4, 1967</b>		22d. ADDRESS <b>2401 - Capitol Hill Wash. D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-6-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Natl Cem.</b>	
23d. LOCATION (City, town or county) <b>Arlington, Virginia</b>		23e. (State)		23f. (County)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>APR 10 1967</b>		24b. REGISTRAR'S SIGNATURE <b>R Charles Judge</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



05315

Items #2b & 7 Film #G287 L/20/57 pc

CERTIFICATE OF DEATH

05313

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admision) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>21 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>HOLY CROSS HOSPITAL</b>		e. STREET ADDRESS <b>1028 UNIVERSITY BLVD. East</b>	
3. NAME OF DECEASED (Type or print) <b>MRS. ESTHER C. CORRIGAN</b>		4. DATE OF DEATH <b>APRIL 9 1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-16-1900</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR: Months <b>9</b> Days <b>19</b> Hours <b>67</b> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookkeeper Govt. Printing Office U.S. Govt.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Howard Webster Foxwell</b>		14. MOTHER'S MAIDEN NAME <b>Hattie M. Foxwell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>215-44-8543</b>	
17. INFORMANT <b>Helen J. Campbell</b>		Address <b>1028 University Blvd. Silver Spring, Md. East</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>10.50 INANITION</b> DUE TO (b) <b>METASTATIC CARCINOMA</b> DUE TO (c) <b>CARCINOMA CECUM</b>		INTERVAL BETWEEN DEATH AND DEATH <b>10.50 MOS 2 YRS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. BUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>Hour a.m. 19 p.m.</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>AUG 1965</b> to <b>APR 9, 1967</b> , that (I) (we) last saw the deceased alive on <b>APR 9 1967</b> , and that death occurred at <b>12:30 PM</b> , from causes on and the date stated above.			
22a. SIGNATURE <b>Leonard L. Deitz</b>		22b. DATE SIGNED <b>APR 10 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>LEONARD L. DEITZ</b>		22d. ADDRESS <b>1106 Spring St. S.S. Mont, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Apr 12, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Prince Georges Co. Md.</b>	
24. FUNERAL DIRECTOR <b>C. Glen Carter</b>		25a. REC'D BY REGISTRAR <b>APR 13 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. ADDRESS <b>8434 Georgia Avenue Warner E. Pumphrey, Inc. Silver Spring, Md.</b>	





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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05316

CERTIFICATE OF DEATH

05314

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN 1b <u>10 1/2 years</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		d. STREET ADDRESS <u>2100 Arcola Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2100 Arcola Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert</u> First Middle Last <u>Humphreys Cox</u>		4. DATE OF DEATH <u>April</u> Month Day Year <u>16</u> <u>19</u> <u>67</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 2, 1906</u>
9. AGE (In years last birthday) <u>60</u> yrs		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Waller Druand Corp.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Davidsonville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Thomas Cox</u>		14. MOTHER'S MAIDEN NAME <u>May E. Humphreys</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO <u>578-03-2084</u>	
17. INFORMANT <u>Nellie U. Cox</u> Address <u>2100 Arcola Avenue Wheaton, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO <u>Coronary Arteriosclerosis</u> (c) <u>Essential Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Essential Hypertension</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 1, 1965</u> to <u>April 16, 1967</u> that (I) (we) last saw the deceased alive on <u>April 16, 1967</u> and that death occurred at <u>7A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John J. Curry</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/16/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John J. Curry</u>		22d. ADDRESS <u>10620 Georgia Ave Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Apr 19, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>
24. FUNERAL DIRECTOR <u>John E. Thomas</u> ADDRESS <u>434 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 18 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05317

CERTIFICATE OF DEATH

05315

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Fairfax</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c LENGTH OF STAY IN lb <b>36 days</b>	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>McLean</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Md. 20014</b>		d STREET ADDRESS <b>7804 Timon Drive</b>	
3 NAME OF DECEASED (Type or print) First <b>Keith</b> Middle <b>Charles</b> Last <b>Culp</b>		4 DATE OF DEATH Month <b>April</b> Day <b>15</b> Year <b>19 67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>May 26, 1962</b>
9 AGE (In years last birthday) <b>4</b> yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>	
10b KIND OF BUSINESS OR INDUSTRY <b>--</b>		11 BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>	
12 CITIZEN OF WHAT COUNTRY? <b>USA</b>		13 FATHER'S NAME <b>Joe C. Culp</b>	
14 MOTHER'S MAIDEN NAME <b>Norma C. Kennan</b>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16 SOCIAL SECURITY NO <b>None</b>		17 INFORMANT <b>The Medical Records, 20014 The Clinical Center, Bethesda, Maryland</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable septicemia</b> DUE TO 2043 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>Pneumonia</b> DUE TO (c) <b>Acute Lymphatic Leukemia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2 days</b> <b>2 1/2 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that <b>he</b> (this hospital) attended the deceased from <b>March 10</b> , 1967, to <b>April 15</b> , 1967, that <b>he</b> (we) last saw the deceased alive on <b>April 15</b> , 1967, and that death occurred at <b>9:50 M</b> , from causes on and on the date stated above.			
22a SIGNATURE <b>Myron J. Levin</b>		22b DATE SIGNED <b>PM 16 April 1967</b>	
22c PHYSICIAN'S NAME (Type) <b>Myron J. Levin, MD</b>		22d ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Maryland</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>April 19, 1967</b>	23c NAME OF CEMETERY OR CREMATORY <b>Pine Crest</b>	23d LOCATION (City or town) (County) (State) <b>Little Rock, Arkansas</b>
24. FUNERAL DIRECTOR <b>Arlington Funeral Home</b>		25. REC'D BY REGISTRAR <b>APR 19 1967</b>	



FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

05318

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05316

1. PLACE OF DEATH a COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Montgomery</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c LENGTH OF STAY IN lb <b>D.O.A.</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		d STREET ADDRESS <b>2005 Cascade Rd.,</b>	
3. NAME OF DECEASED (Type or print) <b>Carl E. Cummins</b>		4. DATE OF DEATH Month <b>April</b> , Day <b>24</b> , Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1914</b> <b>28, Apr, 1914</b>
9. AGE (In years lost birthday) <b>52</b> yrs		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>6</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Major- U.S.A. retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Army</b>	
11. BIRTHPLACE (State or foreign country) <b>Colorado</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James E. Cummins (Decd)</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Ingwelsen (Decd)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO <b>579-52-6461</b>	
17. INFORMANT <b>Maryon Lucille Cummins</b>		Address <b>2005 Cascade Sil Spr</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute myocardial Disease</b> <b>431X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John S. Rogers MD</b>		22. DATE SIGNED <b>4-24-67</b>	
EXAMINER'S NAME (Type) <b>John S. Rogers MD</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr 28, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR <b>C. Glen Carter</b>		25a. REC'D BY REGISTRAR <b>APR 25 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. ADDRESS <b>8434 Georgia Avenue Warner E. Humphrey, Inc. Silver Spring, Md.</b>	



05313

## CERTIFICATE OF DEATH

05317

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>11 mos.</b>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Bethesda-Silver Spring Nursing Home</b>				d. STREET ADDRESS <b>10225 Kensington Pkwy.</b>	
3 NAME OF DECEASED (Type or print) <b>ANGELA DAVIS DASSORI</b>		4 DATE OF DEATH Month <b>April</b> Day <b>1</b> Year <b>19 67</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 16, 1877</b>	9. AGE (In years last birthday) <b>89</b> yrs.	10. IF UNDER 1 YEAR Months <b>1</b> Days <b>19</b> Hours <b>67</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maine</b>	
13. FATHER'S NAME <b>JOHN JACKSON DAVIS</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Frederic Dassori</b> Address <b>Wash., DC</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Collapse</b> 4200 DUE TO <b>Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Arteriosclerotic Heart Disease</b> DUE TO <b>many months</b> (c) <b>many years</b>					INTERVAL BETWEEN ONSET AND DEATH <b>many months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pneumonia, bilateral; arterial thrombosis (lower)</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>1964</b> to <b>April 1, 1967</b> , that (I) (we) last saw the deceased alive on <b>March 30, 1967</b> , and that death occurred at <b>4:10 PM</b> from causes and on the date stated above.					
22a. SIGNATURE <b>George H. Mitchell</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>April 2, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>GEORGE H. MITCHELL</b>		22d. ADDRESS <b>11125 Rockville Pike, Rockville, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-5-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>	
23d. LOCATION (City or Town) <b>Brooklyn, New York</b>		23e. (County)		23f. (State)	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY</b>		ADDRESS <b>BETHESDA, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>APR 7 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)





05320

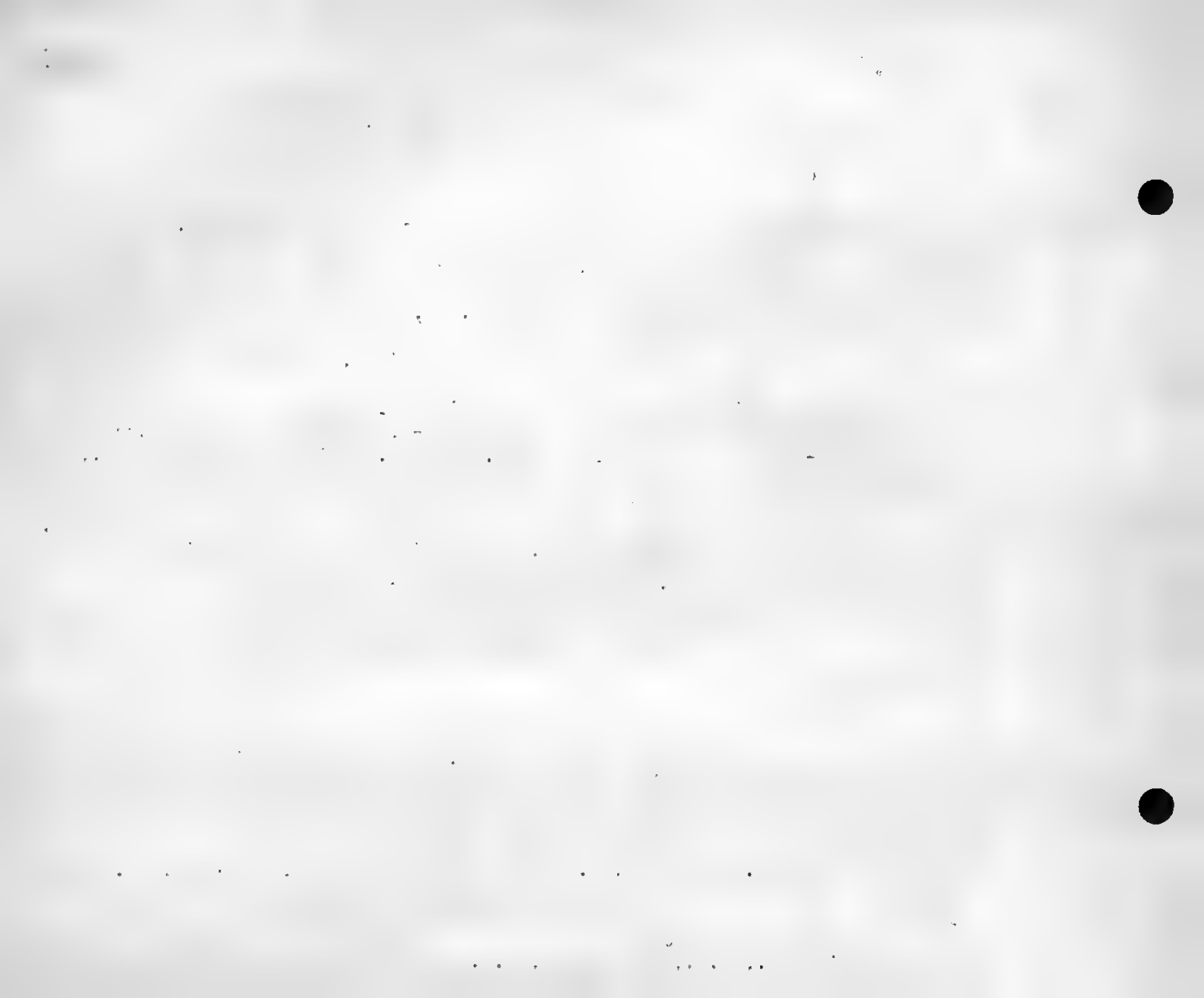
CERTIFICATE OF DEATH

05318

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN 16 <b>177 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Kentucky</b> b. COUNTY <b>Lexington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>				d. STREET ADDRESS <b>304 South Hanover Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Malcolm</b> Last <b>DAVIS</b>		4. DATE OF DEATH Month <b>April</b> Day <b>13</b> Year <b>19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 30, 1906</b>	9. AGE (n years last birthday) yrs. <b>60</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>USMC - Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- -</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Morganfield, Kentucky</b>	
13. FATHER'S NAME <b>Thompson Bennett Davis</b>			14. MOTHER'S MAIDEN NAME <b>Virginia Clements</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes 1930-1960</b>		16. SOCIAL SECURITY NO. <b>- - -</b>		17. INFORMANT <b>C-9, Frankfort</b> Address <b>Kentucky</b> <b>Mrs. Alice M. Davis, 333 East 4th St., APT</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastro-intestinal hemorrhage</b> DUE TO (b) <b>Duodenal ulcer, chronic intestinal obstruction</b> DUE TO (c) <b>Carcinoma of the bladder with carcinomatosis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Approx. 3 weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>Oct. 18, 1966</b> to <b>April 13, 1967</b> , that <del>he</del> (we) last saw the deceased alive on <b>April 13, 1967</b> , and that death occurred at <b>1212 M.</b> from causes and on the date stated above.					
22a. SIGNATURE <b>James L. Snyder, M.D.</b>		22b. DATE SIGNED <b>13 April 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>James L. Snyder, M. D.</b>	
22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4-14-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington Virginia</b>		
24. FUNERAL DIRECTOR <b>Joseph Gawler &amp; Sons</b>		25a. REC'D BY REGISTRAR <b>APR 20 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

05321

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05319

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY in 1b <b>1hr</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Germantown</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Germantown</b> d. STREET ADDRESS <b>Rt #2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Joseph Hayes Davis</b>			4. DATE OF DEATH Month <b>4</b> Day <b>7</b> Year <b>1967</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/30/23</b>	9. AGE (In years lost b rthday) <b>44 yrs</b>	IF UNDER 1 YEAR Months <b>7</b> Days <b>18</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Paint</b>	11. BIRTHPLACE (State or foreign country) <b>Reidville, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Noble Davis</b>			14. MOTHER'S MAIDEN NAME <b>Ethel M. Marsh</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>579-16-7046</b>	17. INFORMANT <b>Wife Christine Rt #2 Germantown Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Multiple extreme injuries incurred in</b> DUE TO (b) <b>head-on auto-auto collision</b> DUE TO (c) <b>lost</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					INTERVAL BETWEEN ONSET AND DEATH		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Deceased, driver, collided head-on with auto which crossed median strip on Rte. 495</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>6:55</b> <b>PM</b> <b>4-7</b> <b>1967</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>	20f. (City or town) <b>Silver Spring Montg. Md.</b>	(County)	(State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Belden R. Reap</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>April 7, 1967</b>			
EXAMINER'S NAME (Type) <b>BELDEN R. REAP, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, City or town, or county)			
23a. BURIAL, CREMATION, or other disposition <b>Reidville, Virginia</b>	23b. DATE THEREOF <b>April 10, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Roseland</b>	23d. LOCATION (City or town) <b>Reidville, Virginia</b>	(County)	(State)		
24. FUNERAL DIRECTOR <b>C. Glen Carter</b>		ADDRESS <b>8434-Ga. Ave</b>		25a. REC'D BY REGISTRAR <b>APR 11 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>		
Warner E. Pumphrey, Inc. Silver Spring, Maryland							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #1c Film #0385 17, 1967

# CERTIFICATE OF DEATH

05322

05320

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington, Md</u>		c. LENGTH OF STAY IN 1b <u>93 69 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Sanitarium</u>				d. STREET ADDRESS <u>3601 Conn. Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James G. DEBEVOISE</u>				4. DATE OF DEATH Month <u>April</u> Day <u>10</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 2, 1879</u>	9. AGE (In years last birthday) <u>88</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>8</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Banking &amp; Trust</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Banking</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Brooklyn, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANK DE BEVOISE</u>				14. MOTHER'S MAIDEN NAME <u>MGT. Pawson.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>068-10-7212</u>		17. INFORMANT <u>Helen Sheldon</u> Address <u>3907 Warner St. Kensington, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>CVA</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u></u>						INTERVA. BETWEEN ONSET AND DEATH <u>2 days</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Undernutrition due to difficulty swallowing</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>67</u> , to <u>April</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>April</u> , 19 <u>67</u> , and that death occurred at <u>12:24</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Marvin Wadler</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/10/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MARVIN WADLER</u>				22d. ADDRESS <u>8218 Wisconsin Avenue</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u>		23b. DATE THEREOF <u>4-11-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Long Island, New York</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR <u>APR 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05323		CERTIFICATE OF DEATH				05321			
1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>			c. LENGTH OF STAY IN IL <u>10 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS <u>16 Maryland Ave</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elsie</u> Middle <u>Willard</u> Last <u>Demory</u>					4. DATE OF DEATH Month <u>April</u> Day <u>23rd</u> Year <u>1967</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 11th 1888</u>		9. AGE (If years lost birthday) <u>79</u> yrs	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>III</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Lovettsville, Va.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Charles W. Spring</u>					14. MOTHER'S MAIDEN NAME <u>Laura J. Spring</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>William L. Demory, Gaithersburg, Md.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) <u>Cerebral signed after consultation with Dr. Galt, Medical Examiner</u>								INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>5 years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>No</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19 <u>  </u> , to <u>April 23, 1967</u> and that death occurred at <u>10 P.M.</u> from causes and on the date stated above.									
22a. SIGNATURE <u>W. A. Linthicum</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/23/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>W. A. Linthicum, M.D.</u>					22d. ADDRESS <u>110 S. Hill St. Rockville, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-26-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lovettsville Union</u>			23d. LOCATION (City or Town) (County) (State) <u>Lovettsville, Va.</u>		
24. FUNERAL DIRECTOR <u>Ernest C. Gartner, Gaithersburg, Md.</u>					25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

APR 26 1967





05324

## CERTIFICATE OF DEATH

05322

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN 1b <b>18 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>			d. STREET ADDRESS <b>3725 Upton Street, N.W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>Carl</b> Last <b>Lewis</b>			4. DATE OF DEATH Month <b>April</b> Day <b>16</b> Year <b>1967</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>May 12, 1897</b>		9. AGE (In years past birthday) yrs. <b>69</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Cleveland, Ohio</b>	
13. FATHER'S NAME <b>Frank Dettmann</b>			14. MOTHER'S MAIDEN NAME <b>Carrie Cliff</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW II</b>		16. SOCIAL SECURITY NO <b>579 44 4133</b>		17. INFORMANT <b>N.W., Washington</b> Address <b>D. C.</b> <b>Mrs. Katherine Dettmann, 3725 Upton St.,</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE LUNG</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Mar. 29</b> , 19 <b>67</b> to <b>Apr. 16</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Apr. 16</b> , 19 <b>67</b> , and that death occurred at <b>2:00 P.M.</b> from causes and on the date stated above.					
22a. SIGNATURE <i>John B. Emery, Jr.</i>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Apr. 17, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>John B. Emery, Jr., M. D.</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4-19-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Va.</b>	
24. FUNERAL DIRECTOR <b>Jos. Gawler &amp; Sons</b> ADDRESS <b>5130 Wisconsin Ave. N.W., Washington, D. C.</b>			25a. REC'D BY REGISTRAR <b>APR 20 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



05325

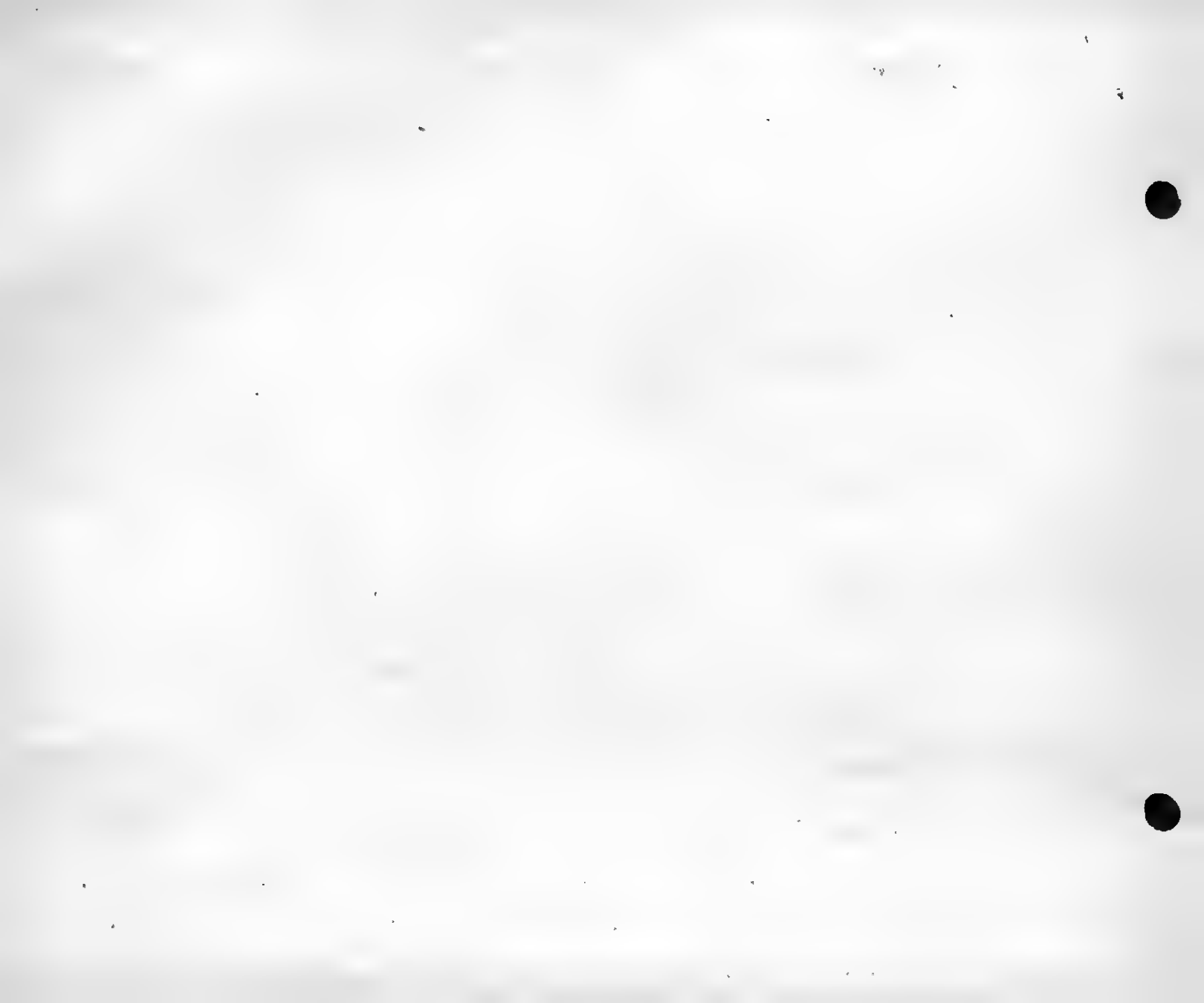
CERTIFICATE OF DEATH

05323

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville - Apt 1502</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dubucon</u>		d. STREET ADDRESS <u>1001 E. Mont. Ave</u>	
3. NAME OF DECEASED (Type or print) <u>RUTH</u>		4. DATE OF DEATH <u>April 17 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/26/1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Penna</u>	
13. FATHER'S NAME <u>John Brady</u>		14. MOTHER'S MAIDEN NAME <u>Catherine M. McCormick</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Daughter - Mrs Cath Scornell</u>		Address <u>same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u> DUE TO (b) <u>Thrombosis left Internal Carotid Artery</u> DUE TO (c) <u>Generalized Atherosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not While <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JAN 15</u> , 19 <u>66</u> , to <u>17 April</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>16 April</u> , 19 <u>67</u> , and that death occurred at <u>7:35 AM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Stanley M. Bialek</u>		22b. DATE SIGNED <u>17 April 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stanley M. Bialek, M. D.</u>		22d. ADDRESS <u>8218 Wisconsin Ave., Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-20-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hanover, Penna.</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>APR 24 1967</u>	25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



VR A15 (4)  
25M 1/67

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>Washington, D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, MD.</u>		c. LENGTH OF STAY IN 1b <u>14 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2015 East West Highway</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY DICKSON</u>		4. DATE OF DEATH <u>April 22 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 26, 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>88</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Gardiner</u>		14. MOTHER'S MAIDEN NAME <u>—</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Robert V. Dickson</u>		Address <u>211 1/2 4th Ave. Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Pulmonary Carcinoma</u> DUE TO <u>103X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Lobar pneumonia + Diabetes</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY <u>2:40 PM 4-22-67</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 1965, to <u>4-22-67</u> , that (I) (we) last saw the deceased alive on <u>4-21</u> 1967, and that death occurred at <u>2:40 PM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Sanford J. Randall</u> M.D.		22b. DATE SIGNED <u>4-22-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>S. J. RANDALL, MD</u>		22d. ADDRESS <u>3001 Vantage Terr. NW</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>—</u>	23b. DATE THEREOF <u>Apr 23, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Columbus Ohio</u>
24. FUNERAL DIRECTOR <u>Charles J. Carter</u> ADDRESS <u>34 Georgia Ave Silver Spring, Md.</u>		25. REC'D BY REGISTRAR <u>APR 27 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



## CERTIFICATE OF DEATH

05327

05325

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>6154 Silver Spring Ave</u>		2. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>6154 Silver Spring Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ann</u> Middle <u>D</u> Last <u>Ditman</u>		4. DATE OF DEATH Month <u>4</u> Day <u>23</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/5/36</u>	9. AGE (In years last birthday) <u>30</u> yrs.	10. IF UNDER 1 YEAR Months <u>4</u> Days <u>23</u> Hours <u>19</u> Min. <u>67</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mass</u>		11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>Walter C. Bullock</u>			14. MOTHER'S MAIDEN NAME <u>Elise Avery</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <u>NO</u> unknown) (If yes give <u>NO</u> dates of service)		16. SOCIAL SECURITY NO <u>006-34-7784</u>		17. INFORMANT <u>William F. Ditman</u> Address <u>Same as #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Melanoma</u> DUE TO (b) <u>Adenocarcinoma of Breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Adenocarcinoma of Breast</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Adenocarcinoma of Breast</u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 4, 1966</u> to <u>4/23, 1967</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>4/23, 1967</u> , and that death occurred at <u>10 P.M.</u> from causes and on the date stated above.					
22a. SIGNATURE <u>G. Lennard Gold</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. Lennard Gold, M.D.</u>		22d. ADDRESS <u>8641 Colesville Rd., Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>4/25/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	
23d. LOCATION (City or Town) <u>Baltimore</u>		23e. (County) <u>Maryland</u>		23f. (State)	
24. FUNERAL DIRECTOR <u>J.T. Stansbury</u>		ADDRESS <u>6411 Windsor Mill Rd.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>APR 26 1967</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

05328

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05326

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN b <b>3 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>555 Thayer Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Peter</b> Middle <b>L.</b> Last <b>Doerflein</b>		4. DATE OF DEATH Month <b>April</b> Day <b>26</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 10, 1896</b>
9. AGE (in years last birthday) <b>70 yrs</b>		IF UNDER 1 YEAR Months <b>70</b> Days <b>70</b> Hours <b>70</b> Min <b>70</b>	IF UNDER 24 HRS Hours <b>70</b> Min <b>70</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Vice President</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Electronic Company</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Louis Doerflein</b>		14. MOTHER'S MAIDEN NAME <b>(unknown)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO. <b>081-28-8220</b>	
17. INFORMANT <b>Ruth Doerflein</b>		Address <b>555 Thayer Avenue Silver Spring, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Fatty metamorphosis of liver with</b> DUE TO <b>Cerebral fat embolism</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Cerebral fat embolism</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Belden R. Keap</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BELDEN R. KEAP M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <b>4/26/1967</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>Apr 26, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Crematory</b>		23d. LOCATION (City or town) (County) (State) <b>Prince Georges Co., Md.</b>	
24. FUNERAL DIRECTOR <b>Glen Carter, 8434 Georgia Avenue Warner E. Pumphrey, Inc. Silver Spring, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 28 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**05329**

**CERTIFICATE OF DEATH**

**05327**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. LENGTH OF STAY IN 1b <b>28 1/2 hrs</b>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON SAN. &amp; HOSPITAL</b>				d. STREET ADDRESS <b>12325 New Hampshire Ave.</b>	
3 NAME OF DECEASED (Type or print) <b>PAULINE BARBARA DONDERO</b>		4. DATE OF DEATH Month <b>4</b> Day <b>1</b> Year <b>1967</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5 SEX <b>FE</b>	6 COLOR OR RACE <b>WH</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>9/24/85</b>	9 AGE (In years lost birthday) <b>81</b> yrs	IF UNDER 1 YEAR Months <b>3</b> Days <b>3</b> Hours <b>19</b> Mins <b>67</b>
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11 BIRTHPLACE (County & State, or foreign country) <b>D.C.</b>	
12 CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>LOUIS LEHMANN</b>			
14. MOTHER'S MAIDEN NAME <b>MARY STEPPER</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No None</b>			
16 SOCIAL SECURITY NO <b>Yes</b>		17 INFORMANT <b>Raphael Dondero</b> Address <b>5602 42nd Ave. HOSPITAL RECORDS S.S., Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>450.1 Acute heart failure</b> DUE TO (b) <b>Gangrene - rt lower leg</b> DUE TO (c) <b>3 days</b>					INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>Oct 15, 1966</b> to <b>April 3, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 3, 1967</b> , and that death occurred at <b>7:00 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>R. H. Sandstrom</b>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>April 3, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>R. H. Sandstrom M.D.</b>		22d. ADDRESS <b>7701 Carroll Ave Takoma Park, Md</b>			
23a. BURIAL, CREMAT., OR REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr 6, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>Prince Georges Co. Md.</b>		24. FUNERAL DIRECTOR <b>John B. Thomas</b> <b>Warner E. Humphrey, Inc.</b> <b>8434 Georgia Avenue Silver Spring, Md.</b>			
25. PREPARED BY REGISTRAR <b>APR 7 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05330

CERTIFICATE OF DEATH

05328

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>...</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. LENGTH OF STAY IN 1b <b>?? DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORREST HEIGHTS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>NAVAL HOSPITAL</b>				d. STREET ADDRESS <b>452 OTTAWA ST.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John Albert Donehoo</b> First Middle Last				4. DATE OF DEATH <b>April 7 19 67</b> Month Day Year			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>CAUC</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>31 DEC 02</b> yrs	
9. AGE (in years last birthday) <b>64</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. NAVY Lt. Comdr. Retired</b>		11. BIRTHPLACE (County & State, or foreign country) <b>ATLANTA, GEORGIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN ALBERT DONEHOO</b>				14. MOTHER'S MAIDEN NAME <b>ALICE UNKNOWN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>578-50-2909 A</b>		17. INFORMANT <b>MRS. IRENE A. DONEHOO</b>		Address <b>#2 Same as Item</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>5810 PRIMARY CIRRHOSIS OF LIVER</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH <b>22 DAYS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>17 MARCH, 1967</b> , to <b>7 APRIL, 1967</b> , that (I) (we) last saw the deceased alive on <b>7 APRIL 67 19</b> , and that death occurred at <b>5:10 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <i>David R. Foreman</i> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>9 April 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>DAVID R. FOREMAN LT, MC, USN</b>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 12-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>ARLINGTON, VIRGINIA</b>	
24. FUNERAL DIRECTOR <b>SIMMONS</b> <b>1661 GOOD HOPE ROAD, SE, WDC</b>				25a. REC'D BY REGISTRAR <b>APR 11 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE  
HEALTH DEPT

05331

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05329

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN TB <u>N/A</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>13020 Turkey Branch Parkway</u>	
3. NAME OF DECEASED (Type or print) <u>John G. Dotsey</u>		4. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> UNMARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 8-1913</u>
9. AGE (in years or birthday) <u>53 yrs</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life ever retired) <u>Hospital Physician</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Dotsey</u>		14. MOTHER'S MARRIED NAME <u>(Unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> 1944-1961		16. SOCIAL SECURITY NO <u>1-09-2507</u>	
17. INFORMANT <u>Mr. John Dotsey - Agent</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> DUE TO (b) <u>Cardio Vascular Disease</u> DUE TO (c) <u>lost</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John B. Ball</u>		22. DATE SIGNED <u>4/18/67</u>	
EXAMINER'S NAME (Type, Print, or Signature) <u>John G. Ball</u>		DEPUTY MEDICAL EXAMINER <u>Charles Judge</u>	
23a. BURIAL, REMOVAL, or CREMATION (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Apr 21, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Washington National Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR <u>Charles Judge</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. DATE <u>APR 24 1967</u>	

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Philadelphia, Pa.



FOR STATE  
HEALTH DEPT.

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
GM 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05332

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05330

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Darnestown.</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>112 Berryville Rd.</u>		d. STREET ADDRESS <u>112 Berryville Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Charles E. Drivers</u>		4. DATE OF DEATH <u>April 23</u> 19 <u>67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 6, 1946</u> 21
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (If years lost birthday) yrs. <u>21</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter Driver</u>		14. MOTHER'S MAIDEN NAME <u>Melouise Jackson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hemopericardium. Massive. Compensated.</u> DUE TO (b) <u>Rupture. Thoracic Aorta, Spontaneous.</u> DUE TO (c) <u>Cystic Medial Necrosis of Aorta, Idiopathic.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John J. Rogers, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John J. Rogers, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Apr. 28, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Seneca Corn. Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Seneca Montg. Md.</u>	
24. FUNERAL DIRECTOR <u>Robert L. Suordea</u>		25a. REC'D BY REGISTRAR <u>APR 27 1967</u>	
ADDRESS <u>Rockville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>William J. Jones</u>	



05333

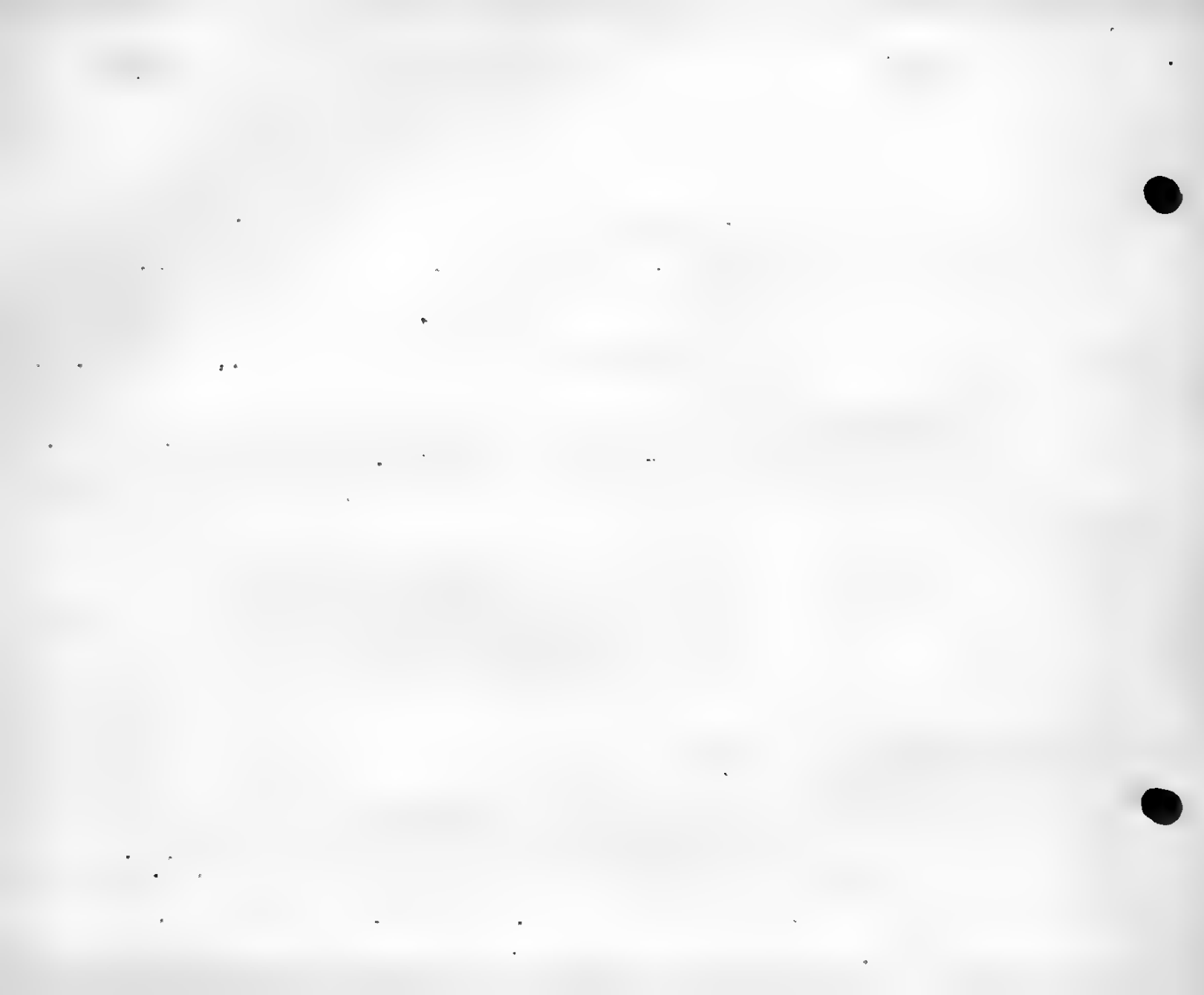
## CERTIFICATE OF DEATH

05331

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN TB	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		d. STREET ADDRESS <b>4743 Bradley Blvd.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4743 Bradley Blvd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ADRIAN</b> Middle <b>O.</b> Last <b>DURHAM, Sr.</b>		4. DATE OF DEATH Month <b>April</b> Day <b>13</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. CO. OR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 6, 1890</b>
9. AGE (In years last birthday) <b>76</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USJAL OCCUPAT ON (Give kind of work done during most of working life, even if retired) <b>Air Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Fairfax County, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Frank Durham</b>		14. MOTHER'S MAIDEN NAME <b>Molly Scott</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I-Navy</b>		16. SOCIAL SECURITY NO <b>579-60-7204</b>	
17. INFORMANT <b>Wife</b>		Address <b>Same as Item 2.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage (Stroke)</b> DUE TO (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH <b>7 1/2 hours</b> <b>10 years</b> <b>20 years</b>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Mar 24</b> , 19 <b>64</b> , to <b>April 13</b> , 19 <b>67</b> , that (I) (we) saw the deceased alive on <b>April 5</b> , 19 <b>67</b> , and that death occurred at <b>2:15</b> P.M. from causes and on the date stated above.			
22a. SIGNATURE <b>R. Stephen Hulburt</b>		22b. DATE SIGNED <b>April 13, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>R. STEPHEN HULBURT</b>		22d. ADDRESS <b>3000 Dent Place, N. W. Washington, D. C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-17-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Natl. Mem. Park Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Falls Church, Virginia</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>APR 17 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2. This certificate should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



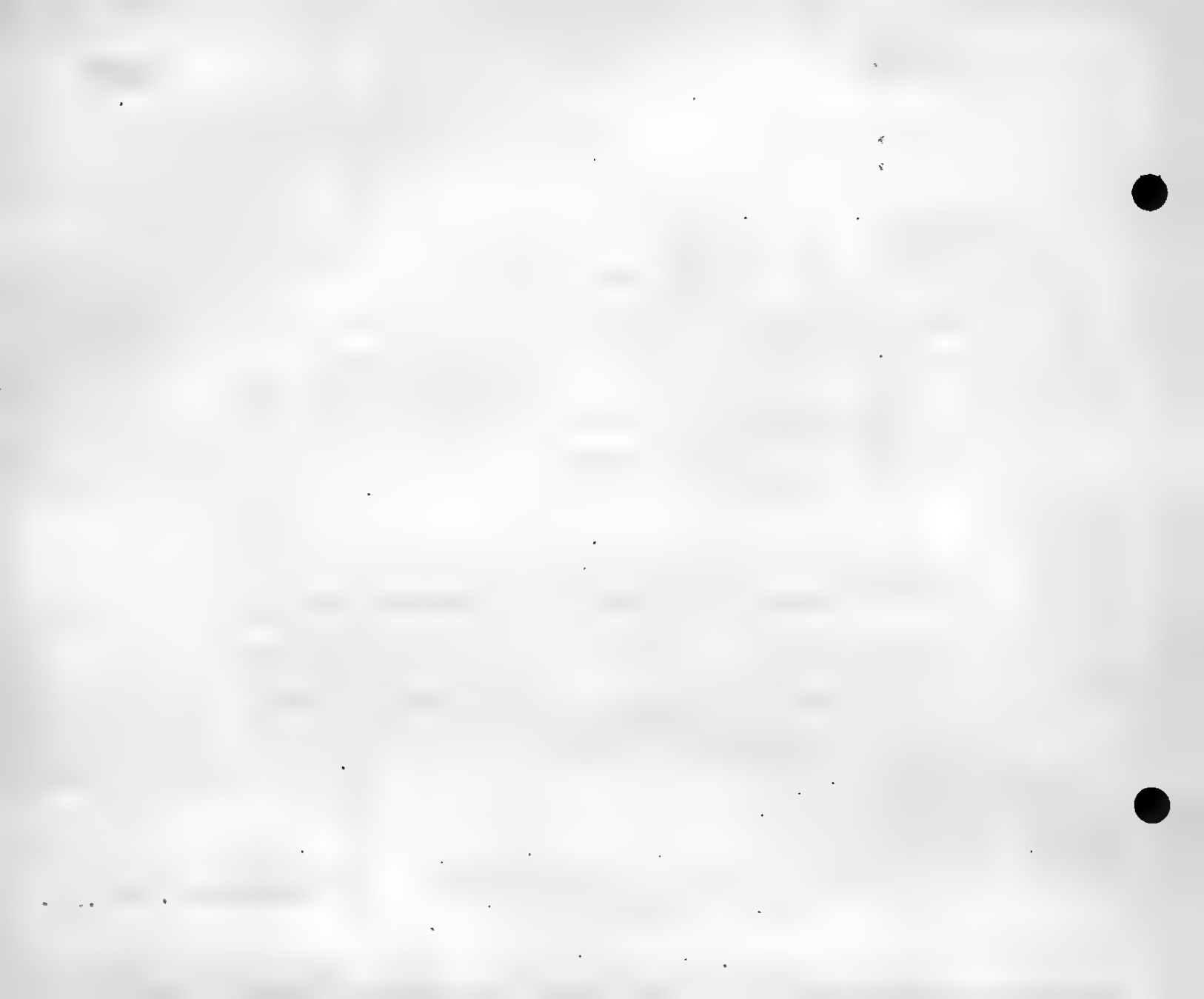
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
05334 CERTIFICATE OF DEATH 05332

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>		e. STREET ADDRESS <u>5 MOORE DRIVE</u>	
3. NAME OF DECEASED (Type or print) First <u>JANICE R.</u> Middle <u>DYSON</u> Last <u>DYSON</u>		4. DATE OF DEATH Month <u>4</u> Day <u>12</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/29/64</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>minor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Dyson</u>		14. MOTHER'S MAIDEN NAME <u>Pamela Gaunt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>-</u>		Address <u>-</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Malignancy</u> DUE TO (b) <u>Wilms Tumor</u> DUE TO (c) <u>-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>2+ yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-10-1967</u> to <u>4-12-1967</u> , that (I) (we) last saw the deceased alive on <u>4-12-1967</u> , and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.				
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>4-13-67</u>
22c. PHYSICIAN'S NAME (Type) <u>ALLAN B. COLEMAN, M.D.</u>		22d. ADDRESS <u>1605 N. PORTLAND R. NW, WASH. DC 20012</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>4/15/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GATES OF HEAVEN</u>	23d. LOCATION (City, town or county) (State) <u>SILVER SPRING, MONTG., MD.</u>	
24. FUNERAL DIRECTOR <u>George R. Ansdem</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		
ADDRESS <u>Rockville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05335

CERTIFICATE OF DEATH

05333

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN TB <b>5415 Burling Road</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5415 Burling Road</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>5415 Burling Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>EDWARD F. DZIURA</b>				4. DATE OF DEATH Month <b>14</b> Day <b>3</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-1-1900</b>		9. AGE (In years last birthday) <b>66</b> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Executive Chief-Retired-Shoreham Hotel</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Joseph Dziura</b>			14. MOTHER'S MAIDEN NAME <b>Florentine Klyck</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>- - -</b>		16. SOCIAL SECURITY NO <b>578-07-6463</b>		17. INFORMANT Address <b>Helen Bell, See Item #2.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> DUE TO (b) <b>HYPERTENSION, CORONARY</b> DUE TO (c) <b>ARTERIOSCLEROSIS, ARTERIES</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>1 year 10-15 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>(GALL STONES)</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour am p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1945</b> , 19 <b>to date</b> , 19 <b>to date</b> , that (I) (we) last saw the deceased alive on <b>4/3</b> , 19 <b>67</b> , and that death occurred at <b>1:15</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Paul R Wilner</b>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>PAUL R WILNER</b>				22d. ADDRESS <b>2500 CALVERT ST. N.W.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-6-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery Prince Georges Co. Md.</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b>				ADDRESS <b>5150 Wisc. Ave. N.W. Wash. D.C.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 10 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>William B. Judge</b>			

1.00  
2.00



1.00 2.00 3.00

4.00

5.00

6.00

7.00 8.00 9.00 10.00



11.00

12.00

13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #4 & 21 from #3001/1/23/67 pc

05336

CERTIFICATE OF DEATH

05334

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. LENGTH OF STAY IN TB <b>6 DAYS</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>NAVAL HOSPITAL</b>				d. STREET ADDRESS <b>3900 CALVERTON DRIVE</b>	
3. NAME OF DECEASED (Type or print) <b>EDWIN SHELL EARNHARDT</b>		4. DATE OF DEATH <b>APRIL 14 1967</b>		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUC</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUN. 10, 1895</b>	9. AGE (in years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Captain US NAVY</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		11. BIRTHPLACE (County & State, or foreign country) <b>LENOIR, N. CAROLINA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>UNKNOWN Earnhardt</b>		14. MOTHER'S MAIDEN NAME <b>BLANCHE UNKNOWN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>WW I &amp; 2</b>		17. INFORMANT <b>GLADYS R. EARNHARDT</b> <b>3900 CALVERTON DRIVE HYATTSVILLE, MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Severe Coronary Atherosclerotic Cardiovascular Disease</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20a. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that <del>he</del> (this hospital) attended the deceased from <b>APR 9</b> , 1967, to <b>APR 14</b> , 1967, that <del>he</del> (we) last saw the deceased alive on <b>APR 14</b> , 1967, and that death occurred at <b>2325H</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>W.H. Spaur</b>		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>16 April 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. H. SPAUR, LCDR MC USN</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-18-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>	
23d. LOCATION (City or Town) (County) (State) <b>ARLINGTON VA.</b>		24. FUNERAL DIRECTOR <b>FRANCIS GASCH'S SONS, HYATTSVILLE, MD.</b>			
25a. REC'D BY REGISTRAR <b>APR 18 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



FOR STATE HEALTH DEPT

05337

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05335

1. PLACE OF DEATH a. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Montgomery</b> <b>Takoma Park</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Maryland</b> <b>Seat Pleasant</b>	
c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		d. STREET ADDRESS <b>5264 Marbough Pike</b>	
e. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington San + Hosp.</b>		f. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Dominic Thomas Emelio</b>		4. DATE OF DEATH Month <b>4</b> Day <b>27</b> Year <b>1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-16-38</b>
9. AGE (In years last birthday) yrs <b>28</b>		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>27</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steel Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>D.C.</b>	
11. BIRTHPLACE (State or foreign country) <b>D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>D.C.</b>	
13. FATHER'S NAME <b>Salvatore D. Emelio</b>		14. MOTHER'S MAIDEN NAME <b>Mary Hessler</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes</b>		16. SOCIAL SECURITY NO <b>157-286486</b>	
17. INFORMANT <b>Mary J. Emelio</b>		Address <b>Wash DC</b> <b>3966 PA Ave SE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Multiple extreme fractures of the left femur, left ilium, left arm and ribs with exsanguination</b> DUE TO (b) <b>femur, left ilium, left arm and ribs</b> DUE TO (c) <b>with exsanguination</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			INTERVAL BETWEEN ONSET AND DEATH
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Deceased found dead beside wrecked motorcycle on Riggs Road</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>2:50</b> p.m. <b>4-27 1967</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>Street</b>		20f. (City or town) (County) (State) <b>Hyattsville PrGeo Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <b>Accident</b> <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Belden R. Read</b>		22. DATE SIGNED <b>4/28/1967</b>	
EXAMINER'S NAME (Type) <b>BELDEN R. READ, M.D.</b>		23. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>May 2-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Alexandria Nat'l. Cemetery Alexandria, Virginia</b>	
24. FUNERAL DIRECTOR <b>Simmons Bros.</b>		25. REC'D BY REGISTRAR <b>DATE MAY 1 1967</b>	
Address <b>1661 Good Hope Rd SE Wash DC</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="display: flex; justify-content: space-between;"> <div>05338</div> <div> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div> <div>05336</div> </div>											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Olney</u>					
c. LENGTH OF STAY IN 1b <u>7 months</u>						d. STREET ADDRESS <u>Montgomery Conv. &amp; Nursing Home</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Charlotte E. G. FARQUHAR</u>						4. DATE OF DEATH <u>4-29-1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-22-1874</u>		9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Griffith</u>						14. MOTHER'S MAIDEN NAME <u>Elizabeth Singleton</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war dates of service)						16. SOCIAL SECURITY NO. <u>215-48-3814</u>		17. INFORMANT <u>Mrs. Catherine Wilcox</u> Address <u>Gaithersburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema, acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>status asthmaticus cardiovascular disease</u> DUE TO (c) <u>20 yrs</u>										INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-9-1966</u> to <u>4-29-1967</u> , that (I) (we) last saw the deceased alive on <u>4-28-1967</u> , and that death occurred at <u>P. M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>A.D. Bonifant</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>A.D. Bonifant, M.D.</u>						22b. DATE SIGNED <u>5/1/67</u>					
22d. ADDRESS <u>Medical Center, Sandy Spring, Maryland</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)			
<u>Burial</u>			<u>5-2-67</u>		<u>St. Johns</u>			<u>Olney, Md.</u>			
24. FUNERAL DIRECTOR <u>Francis H. Barber</u> <u>Laytonsville, Md.</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					
DATE <u>MAY 3 1967</u>											



05333

## CERTIFICATE OF DEATH

05337

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN Tb <u>5 1/2 hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery General Hospital</u>		d. STREET ADDRESS <u>Sykesville</u>	
3. NAME OF DECEASED (Type or print) <u>FINCHAM, BABY BOY</u>		4. DATE OF DEATH Month <u>4</u> Day <u>16</u> Year <u>67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-16-67</u>
9. AGE (In years last birthday) yrs. <u>5</u>		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>20</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co. Montgomery, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Perry Hankins</u>		14. MOTHER'S MAIDEN NAME <u>Mary Fincham</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>Olney, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>770X pol. multiplicity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April 16, 1967</u> to <u>April 16, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 16, 1967</u> , and that death occurred at <u>1005 M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Chester Wagstaff</u>		22b. DATE SIGNED <u>4-17-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Chester Wagstaff</u>		22d. ADDRESS <u>Sandy Spring Med. Center, Sandy Sp.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>4-18-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HARMONY Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Howard Co. Md.</u>
24. FUNERAL DIRECTOR <u>Harry W. Haight Sykesville, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 21 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05340

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05338

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Great Falls</u>		c. LENGTH OF STAY IN 1b <u>Penns Grove</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Parking Lot</u>		d. STREET ADDRESS <u>337 N. Broad St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ian Edward Finlayson</u>		4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 8, 1940</u>
9. AGE (In years lost birthday) <u>26</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USLA. OCCUPATION (Give kind of work done during most of working life even if retired) <u>U. S. NAVY</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>CAMBRIDGE, MASS.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>DONALD J. FINLAYSON (DEC'D)</u>		14. MOTHER'S MAIDEN NAME <u>ELEANOR PETERSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) <u>YES</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>068 32 5070</u>	
17. INFORMANT <u>NAVY RECORDS</u>		Address <u>USNH BETHESDA, MARYLAND</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shot Gun blast of Head Self inflicted</u> <u>4/16A</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Muzzle of shotgun in mouth + pulled trigger blowing off Head</u>	
20c. TIME OF INJURY Month Day, Year Hour <u>4:30</u> am <u>4/26</u> 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Parking Lot</u>		20f. (City or town) <u>Great Falls Mont.</u> (County) <u>Md.</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		M.D.	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		22. DATE SIGNED <u>4/26/67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>4-29-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>FI LINCOLN</u>		23d. LOCATION (City or town) (County) (State) <u>Ar. Geo. Co. Md</u>	
24. FUNERAL DIRECTOR <u>W.W. Chambers Co 1400 Chapin St</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAY 1 1967</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
053341 Items #2c & d Film #0287 4/19/67											
053339											
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Burtonville</i>						c. LENGTH OF STAY IN ID <i>14.3 months</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Lippard's Home for Senior Citizens</i>						d. STREET ADDRESS <i>1208 Noves Dr. Burtonville, Md.</i>					
3. NAME OF DECEASED (Type or print) <i>Mary Stella Fleisher</i>						4. DATE OF DEATH <i>Apr 10 1967</i>					
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Dec 5 1898</i>		9. AGE (In years last birthday) <i>68 yrs.</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Secretary</i>						11. BIRTHPLACE (County & State, or foreign country) <i>Newport, Penna.</i>					
13. FATHER'S NAME <i>William Fleisher</i>						14. MOTHER'S MAIDEN NAME <i>Eizabeth Thatcher</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO. <i>220-44-8448</i>					
17. INFORMANT <i>Mary Stella Fleisher</i>						18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Thrombosis of basal artery of Brain.</i> DUE TO (b) <i>Chronic Myocarditis - mitral regurg - since 1945</i> DUE TO (c) <i>1945</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <i>7/25/1937</i> to <i>4/10/1967</i> , that (I) (we) last saw the deceased alive on <i>4/7/1967</i> , and that death occurred at <i>8:15 P.M.</i> from the causes and on the date stated above.											
22a. SIGNATURE <i>Howard T. Morse</i>						22b. DATE SIGNED <i>4/18/67</i>					
22c. PHYSICIAN'S NAME (Type) <i>Howard T. Morse, M.D.</i>						22d. ADDRESS <i>2030 Carroll Ave Takoma Park, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>						23b. DATE THEREOF <i>April 13, 1967</i>					
23c. NAME OF CEMETERY OR CREMATORY <i>Newport Cemetery</i>						23d. LOCATION (City, town or county) (State) <i>Newport, Penna.</i>					
24. FUNERAL DIRECTOR <i>Arthur Walters</i>						25a. REC'D BY REGISTRAR <i>APR 13 1967</i>					
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05342 Items 8 & 9 Film					05340				
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Wisconsin</b> b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN 1b <b>4-17-65 - 4-16-67</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GREEN BAY</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Westwood Retirement Home</b>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ANTOINETTE</b>			First Middle Last <b>R. FLYNN</b>		4. DATE OF DEATH Month <b>4</b> Day <b>16</b> Year <b>1967</b>				
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-1-1876</b>		9. AGE (In years last birthday) <b>90</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Wisconsin</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>MICHEL RESCH</b>					14. MOTHER'S MAIDEN NAME <b>AMELIA FRANK</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>ELEANOR FLYNN, 50, WINDEMERE ROAD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary occlusion</b> DUE TO (b) <b>Arteriosclerosis.</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									INTERVAL BETWEEN ONSET AND DEATH <b>Several yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Unknown.</b>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N.A.</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>4/16, 1967</b> , to <b>4/16, 1967</b> , that (I) (we) last saw the deceased alive on <b>N.A.</b> 19__, and that death occurred at <b>10 A.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Rafael A. Burgos, M.D.</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>16 April 1967</b>		
22c. PHYSICIAN'S NAME (Type) <b>RAFAEL A. BORGOS.</b>					22d. ADDRESS <b>2101-16th St., N.W., Washington, D.C.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>4-19-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Green Bay, Wisc.</b>			
24. FUNERAL DIRECTOR <b>GAWLER Wash. D.C.</b>					25a. REC'D BY REGISTRAR <b>APR 21 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Cleared by Medical Examiner

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
05343 Item #7 Film #05343 4/17/67 05341													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>							
c. LENGTH OF STAY IN 1b						d. STREET ADDRESS <u>13216 Sherrill Road</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital - D.C.A.</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>FRANCIS KILTARE FLYNN</u>						4. DATE OF DEATH <u>April 11, 1967</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 4, 1892</u>		9. AGE (in years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Mechanical Engineer</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>James Flynn</u>						14. MOTHER'S MAIDEN NAME <u>Sarah Marion</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give year or dates of service)		17. INFORMANT Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4371 DUE TO (b) <u>Hypertensive Arteriosclerotic Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Arteriosclerosis Generalized</u>												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>15 Feb</u> , 19 <u>67</u> , to <u>11 Apr</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1 Apr</u> , 19 <u>67</u> , and that death occurred at <u>2:40 PM</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>Ronan P. Fogarty</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS <u>11 Apr 67</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF <u>4/14/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Luke's Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Colonar Manor Md.</u>					
24. FUNERAL DIRECTOR <u>J. Walter Walters</u>				ADDRESS <u>254 Carroll St N.W.</u>		25a. REC'D BY REGISTRAR <u>APR 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					





## CERTIFICATE OF DEATH

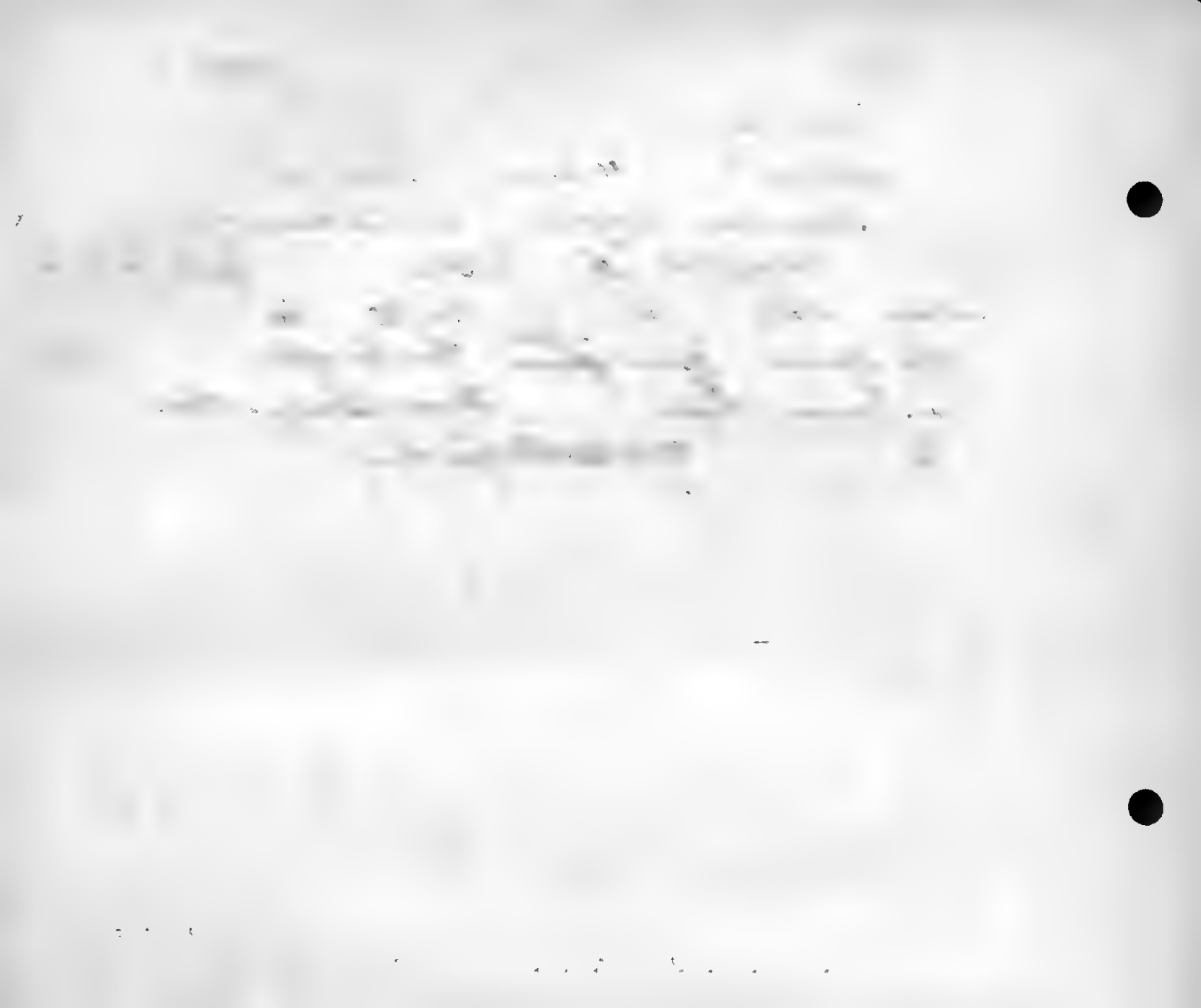
05344

05342

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>DC</i> b. COUNTY <i>1</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>11 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>		d. STREET ADDRESS <i>5103 Brookview Dr</i>	
3 NAME OF DECEASED (Type or print) <i>KENNETH A. FOOTE</i>		4. DATE OF DEATH Month <i>April</i> Day <i>24</i> Year <i>1967</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>11/11/00</i>
9. AGE (In years and birthday) <i>66</i> yrs		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sales Manager</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Philco Electrical Appliances</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>New Hampshire</i>		12 CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13 FATHER'S NAME <i>R. Hanson Foote</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Henry - Abow</i>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16 SOCIAL SECURITY NO <i>577-03-8664</i>	
17. INFORMANT <i>John M. King III, Sec. Serv. #2</i>		Address	
18 CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory failure</i> DUE TO (b) <i>Massive Cerebral Thrombosis</i> DUE TO (c) <i>Generalized Arteriosclerosis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hypertension</i>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>April 14</i> , 1967, to <i>April 24</i> , 1967, that (I) (we) last saw the deceased alive on <i>April 24</i> , 1967, and that death occurred at <i>3:30 PM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Edward S. Witowski</i>		22b. DATE SIGNED <i>April 24, 1967</i>	
22c. PHYSICIAN'S NAME (Type) <i>DR. Edward S. Witowski</i>		22d. ADDRESS <i>8218 - WISCONSIN AVE. N.W. WASH. D.C.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>4-27-1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Washington, D.C.</i>
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. DATE <i>MAY 2 1967</i>	



05343

05345

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if "institution" Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>2 days</u>		d. STREET ADDRESS <u>8607 Mayfair Place</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Lincoln</u> Last <u>Freeman</u>		4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/10/80</u> <u>87</u>
9. AGE (In years last birthday) <u>87</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Army Major</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Army</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Unknown</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>1 25 3125</u>		17. INFORMANT <u>Ressie B. Freeman</u> Address <u>8607 Mayfair Place</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pulmonary Infarction Rt Lower Lobe</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>17 Apr</u> , 1967, to <u>18 Apr</u> , 1967, that (I) (we) last saw the deceased alive on <u>Apr 18</u> , 1967, and that death occurred at <u>1:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>James W Eagan</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>JAMES W EAGAN</u>		22d. ADDRESS <u>5413 CEDAR LANE, BETHESDA MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Apr 22, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u>
24. FUNERAL DIRECTOR <u>James W Eagan</u> ADDRESS <u>434 Georgia Avenue</u>		25. REC'D BY REGISTRAR <u>APR 26 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.



05346

CERTIFICATE OF DEATH

05346

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>University Nursing Home, 901 Arcola Rd.</u>		d. STREET ADDRESS <u>9201 2nd Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Lewis Cass Gabbert</u>		4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/21/1874</u>
9. AGE (In years lost birthday) <u>93</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Dearborn, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benton Gabbert</u>		14. MOTHER'S MAIDEN NAME <u>Alice Layton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-54-2840</u>	
17. INFORMANT <u>Lewis C. Gabbert, Jr.</u>		Address <u>9201 2nd Avenue Silver Spring</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Death myocardial infarction</u> DUE TO (b) <u>Chronic myocardial infarction</u> DUE TO (c) <u>Myocardial infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April 2, 1967</u> to <u>April 3, 1967</u> that (I) (we) last saw the deceased alive on <u>April 2, 1967</u> , and that death occurred at <u>2:45 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John Rogers, M.D.</u>		22b. DATE SIGNED <u>4-3-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John Rogers, M.D.</u>		22d. ADDRESS <u>1919 Seminary Rd., Silver Spring, Md.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Trans-burial</u>	23b. DATE THEREOF <u>April 6, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Moriah Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>St. Joseph, Missouri</u>
24. FUNERAL DIRECTOR <u>John B. Thomas, 8434 Georgia Avenue</u> <u>Barner E. Pamphrey, Inc., Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 7 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



Cleared Medical Examiner - Dr. Rogers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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1

(M)

05347

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05345

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>DICKERSON, MD</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dickerson</u>		c. LENGTH OF STAY IN 1b <u>17 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DICKERSON, MD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Potomac Valley Nursing Home</u>			d. STREET ADDRESS <u>RT. #1 THURSTON RD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>William BRUCE Galloway</u>			4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>1967</u>		
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>WHITE</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12-8-1883</u>	9 AGE (In years last birthday) yrs. <u>83</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCHOOL TEACHER PUBLIC SCHOOL</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (County & State, or foreign country) <u>COAT BRIDGE SCOTLAND</u>	
13 FATHER'S NAME <u>JAMES GALLOWAY</u>			12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>			16 SOCIAL SECURITY NO <u>480-30-3953</u>		
17 INFORMANT <u>Charles E. Apple</u>			Address <u>Rt. #1 Dickerson, Md.</u>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>  </u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Fracture Rt Hip</u> <u>Generalized Arteriosclerosis</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Fracture Rt Hip at Home in Fall 3/10/67</u>			
20c. TIME OF INJURY Month, Day, Year <u>11</u> Hour <u>a.m.</u> <u>3:10</u> <u>1967</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u>		20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21 I certify that (I) ( <u>this hospital</u> ) attended the deceased from <u>1963</u> to <u>4/21</u> , 19 <u>67</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>4/21</u> , 19 <u>67</u> , and that death occurred at <u>3:10</u> P.M., from causes and on the date stated above					
22a. SIGNATURE <u>James W. Egan</u>			M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>4/21/67</u>
22c. PHYSICIAN'S NAME (Type) <u>JAMES W. EGAN</u>			22d. ADDRESS <u>  </u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-24-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem.</u>	
23d. LOCATION (City or Town) <u>Fredrick</u>		(County) <u>Fred. Md.</u>		(State) <u>  </u>	
24. FUNERAL DIRECTOR <u>Salamone Funeral Home</u>			ADDRESS <u>Fredrick, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 24 1967</u>
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

VR A15 (4)  
25M 1/67





05346

## CERTIFICATE OF DEATH

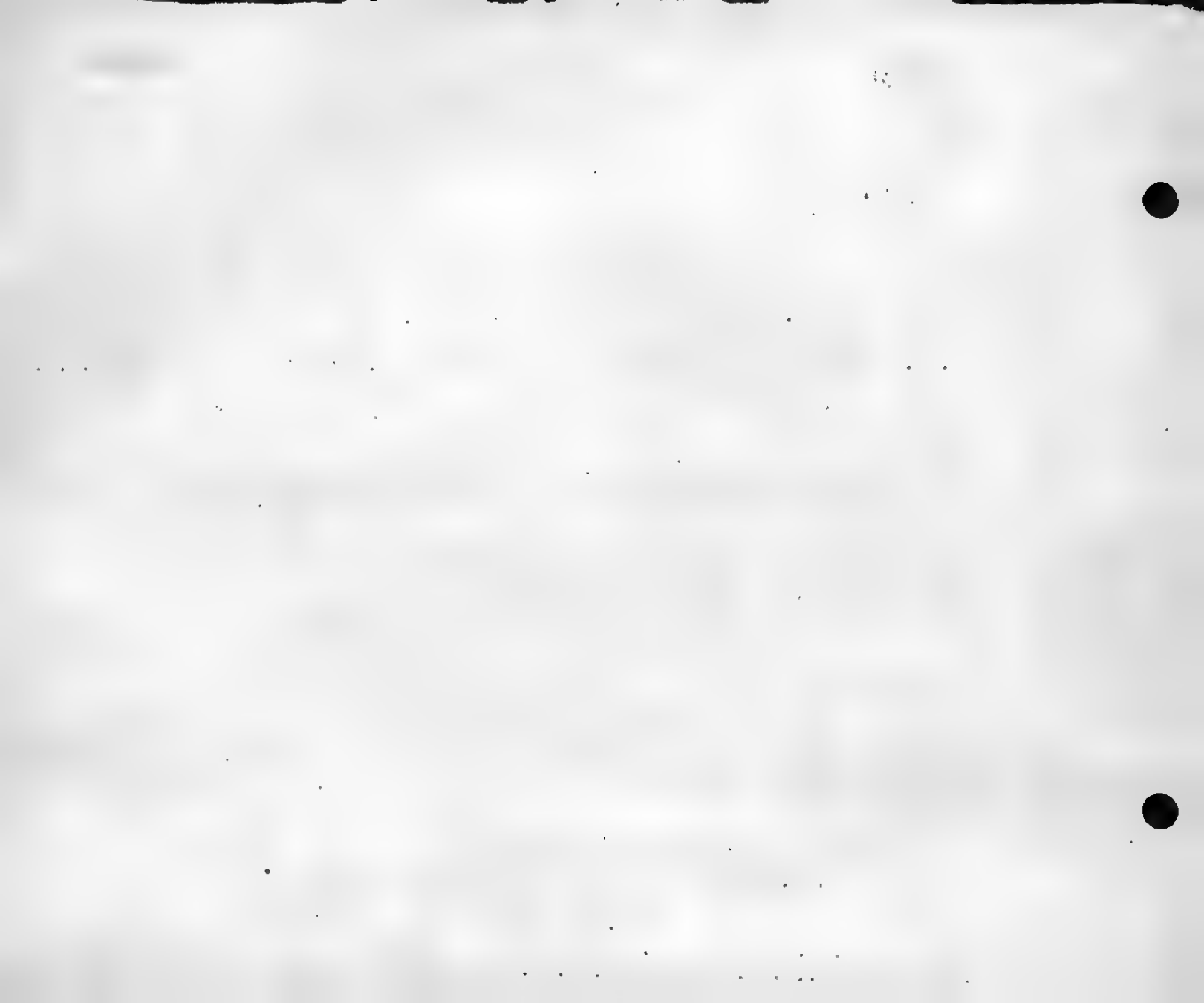
05346

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>New York</b> b. COUNTY <b>CORTLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN 1b <b>35 Days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cortland</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Naval Hospital</b>		d. STREET ADDRESS <b>47 Hubbard Street</b>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>ANTHONY</b> Last <b>GALUTZ</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>20</b> Year <b>19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUC.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 14, 1946</b>
9. AGE (In years last birthday) yrs <b>20</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. MARINE CORP</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Cortland, New York</b>	
13. FATHER'S NAME <b>Anthony Galutz</b>		14. MOTHER'S MAIDEN NAME <b>Lena EX Piedigrossi</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>YES</b> <b>Police Duty</b>		16. SOCIAL SECURITY NO <b>059 38 1587</b>	
17. INFORMANT <b>Navy Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <b>GUNSHOT WOUND OF HEAD (Received as a result of action in Viet Nam)</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>17 MAR 67</b> , 19__, to <b>20 APR 67</b> , 19__, that (I) (we) last saw the deceased alive on <b>20 APR 67</b> , 19__, and that death occurred at <b>11 A.M.</b> , from causes and on the date stated above			
22a. SIGNATURE <b>D. K. ROEDER</b>		22b. DATE SIGNED <b>21 APR 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>D. K. ROEDER</b>		22d. ADDRESS <b>NAVAL HOSPITAL - BETHESDA, MD</b>	
23a. BURIAL, CREMATION, REMAINS <b>Burial</b>		23b. DATE THEREOF <b>4-24-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Cortland New York</b>	
24. FUNERAL DIRECTOR <b>W. W. Chambers Co.</b>		25a. REC'D BY REGISTRAR <b>APR 25 1967</b>	
1400 Chapin St., N. W. Washington, D.C.		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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VR A15 (4)  
20 M 1-66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05349

05347

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>2 Days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>		d. STREET ADDRESS <i>Greenridge Dr. P.O. Box 134</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>MARY A Gilbert</i>		4. DATE OF DEATH Month Day Year <i>April 14 1967</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/31/88</i>
9. AGE (In years last birthday) <i>79</i> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>Kansas</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James Hutchell</i>		14. MOTHER'S MAIDEN NAME <i>Lydin Crull</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>524-09-5750</i>	
17. INFORMANT <i>husband</i>		Address <i>Same as Item 2.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>UREMIA</i> DUE TO (b) <i>Acute Peritonitis</i> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <i>4-5 days</i> <i>4-5 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>4-12</i> , 19 <i>67</i> , to <i>4-14</i> , 19 <i>67</i> , that (I) (we) lost saw the deceased alive on <i>4-13</i> , 19 <i>67</i> , and that death occurred at <i>11:20 AM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>DeWitt E. DeLauter</i>		22b. DATE SIGNED <i>4-14-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>DeWitt E. DeLauter</i>		22d. ADDRESS <i>8025 ABERDEEN RD Bethesda Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial-transit</i>	23b. DATE THEREOF <i>4-15-67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Howell Mem. Park</i>	23d. LOCATION (City or Town) (County) (State) <i>West Plains, Missouri</i>
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		25a. REC'D BY REGISTRAR <i>APR 17 1967</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05350

05348

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u> c. LENGTH OF STAY IN ID <u>15 Silver Spring Avenue Apt 309</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>15 Silver Spring Avenue Apt 309</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>415 Silver Spring, Ave Apt. 309</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Joseph</u> Last <u>Gilrain</u>		4. DATE OF DEATH Month <u>4</u> Day <u>21</u> Year <u>67</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-1-1899</u>		9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Post Office</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>				11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>															
13. FATHER'S NAME <u>James J. Gilrain</u>				14. MOTHER'S MAIDEN NAME <u>Elle Donaher</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>James Gilrain</u> Address <u>"Maple" Restaurant Worcester, Mass.</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)															
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																											
ACTUAL SIGNATURE <u>John S. Rogers</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED <u>4-21-67</u>											
EXAMINER'S NAME (Type) <u>John S. Rogers, M.D., 1919 Seminary Rd Silver Spring, Md.</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>												23b. DATE THEREOF <u>Apr 25, 1967</u>				23c. NAME OF CEMETERY OR CREMATORY <u>St. John Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Worcester, Mass.</u>			
24. FUNERAL DIRECTOR <u>John S. Rogers, M.D., 1919 Seminary Rd Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR <u>APR 27 1967</u>				25b. REGISTRAR'S SIGNATURE <u>John S. Rogers</u>																			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
05351 CERTIFICATE OF DEATH 05349

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>UNIVERSITY NURSING HOME</u>		e. STREET ADDRESS <u>806-Malecon Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Blanche</u> Middle <u>Goldberg</u> Last <u>Goldberg</u>		4. DATE OF DEATH Month <u>4</u> Day <u>15</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-23-1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>NEWELLTON LA.</u>
13. FATHER'S NAME <u>ABRAHAM Solomon</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>459-86-3525</u>	
17. INFORMANT <u>MRS. T. W. FRIEDMAN</u>		Address <u>806-Malecon Dr. S.S.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO (b) <u>ARTERIOSCLEROTIC Heart Disease</u> DUE TO (c) <u>10 years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (u) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>67</u> to <u>APRIL</u> , 19 <u>67</u> , that (v) (we) last saw the deceased alive on <u>4/13</u> , 19 <u>67</u> , and that death occurred at <u>12:00 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>M. Shapiro</u>		22b. DATE SIGNED <u>4/15/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MORTON SHAPIRO</u>		22d. ADDRESS <u>8107-EASTERN AVE - S.S. MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/19/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Natchez Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Natchez, Mississippi</u>
24. FUNERAL DIRECTOR <u>B. Banzansky &amp; Sons, 3501-14th St NW</u>		25a. REC'D BY REGISTRAR <u>APR 18 1967</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05352		05350	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10213 McKenney Ave</u>		d. STREET ADDRESS <u>10213 McKenney Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>xpax</u> Last <u>GORKA</u>		4. DATE OF DEATH Month <u>Apr</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 30 1896</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Chef</u>		9b. KING OF BUSINESS OR INDUSTRY <u>Kammels Restaurant</u>	9c. BIRTHPLACE (County & State, or foreign country) <u>Poland</u>
10a. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Paul Gorka</u>		14. MOTHER'S MAIDEN NAME <u>Ludwika Gorka</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-01-73619</u>	
17. INFORMANT <u>Mrs Florence Gorka</u>		Address <u>10213 McKenney Ave. Silver Spring Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Coronary insufficiency</u> DUE TO (c) <u>6 yrs</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 min</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Mar</u> , 1967, to <u>Apr 18</u> , 1967, that (I) (we) last saw the deceased alive on <u>Apr 18</u> , 1967, and that death occurred at <u>7:00 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>John Lawrence Avery</u>		22b. DATE SIGNED <u>Apr 19, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>John Lawrence Avery</u>		22d. ADDRESS <u>10620 Georgia Ave. Silver Spring Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Apr 22, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>
24. FUNERAL DIRECTOR <u>John B. Hoar</u>		25a. REC'D BY REGISTRAR <u>John B. Hoar</u>	
25b. REGISTRAR'S SIGNATURE <u>John B. Hoar</u>		DATE <u>APR 26 1967</u>	

Medical examiners' office notified JHA

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, marking the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

Items 10a & B, 11, 12, 14 & 17 Fill in 3, 5, 7, 4, 10, 17, 18, 19

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**05351**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Parking Lot Sacks Department Store</b>		d. STREET ADDRESS <b>4 West Kirke Street</b>	
3. NAME OF DECEASED (Type or print) <b>Deborah Wilds Granger</b>		4. DATE OF DEATH Month <b>April</b> Day <b>3</b> Year <b>1967</b>	
5. SEX <b>Fe</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 28, 1932</b> 9. AGE (In years lost birthday) <b>34</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Easton, Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Newlin D. Wildes</b>		14. MOTHER'S MAIDEN NAME <b>Faith Lovell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>--</b>		16. SOCIAL SECURITY NO. <b>--</b>	
17. INFORMANT <b>Michael Mulrone, son of deceased</b> Address <b>D-2 St., Al. Md. r.</b> <b>same</b> <b>Van</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Laceration &amp; Maceration of Brain</b> <b>976X</b> DUE TO (b) <b>Gun Shot Wound of Head.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <b>suicidal</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Shot Sept. in Rtside of head with derringer 22 cal.</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>2:30</b> p.m. <b>4/3</b> 1967	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>in Car</b>	20f. (City or town) <b>Bethesda</b> (County) <b>Montgomery</b> (State) <b>Md</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John S. Ball</b> M.D.		22. DATE SIGNED <b>4/4/67</b>	
EXAMINER'S NAME (Type) <b>John S. Ball</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>	23b. DATE THEREOF <b>4/5/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>	23d. LOCATION (City or town) (County) (State) <b>Suitland, Md.</b>
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, 5130 Wisc. Ave. NW, Wash. DC</b>		25a. REC'D BY REGISTRAR <b>APR 10 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



05354

CERTIFICATE OF DEATH

Reg. Dist. No. 05352

1. PLACE OF DEATH a. COUNTY <u>Montgomery,</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington,</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bethesda-Silver Spring Nursing Home.</u>				d. STREET ADDRESS <u>4422 N. Street, N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary E. Hagan</u>				4. DATE OF DEATH Month Day Year <u>April 20, 1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 18, 1871</u>	9. AGE (In years last birthday) <u>96</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Dist. of Col.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Robert DeLay</u>				14. MOTHER'S MAIDEN NAME <u>Wallace</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-48-4090</u>		17. INFORMANT <u>Grand-Daughter.</u> Address <u>Mrs. Logan E. Hill Wash. D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cholangitis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>---</u> DUE TO (c) <u>---</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>22 March, 1967</u> to <u>20 April, 1967</u> , that I last saw the deceased alive on <u>15 Apr. 1967</u> , and that death occurred at <u>8:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4740 Cherry Chase Dr. Prince Georges Co. Maryland.</u> DATE SIGNED <u>21 Apr 67</u>							
ACTUAL SIGNATURE <u>Herbert Martyn</u>		M.D. <u>HERBERT MARTYN JR Cherry Chase Md</u>					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 25, 1967</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Bon. Kellogg</u>				ADDRESS <u>2222 Wis. Ave. N.W. Washington, D.C. 20007</u>		24a. REC'D BY REGISTRAR DATE <u>Apr 28 1967</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

05355

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05353

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN or outside corporate limits, write RURAL and give nearest town <u>Takoma Park</u>		c. CITY OR TOWN or outside corporate limits, write RURAL and give nearest town <u>Takoma Park</u>	
c. LENGTH OF STAY IN 1b <u>DO A</u>		d. STREET ADDRESS <u>4 Dornier Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San + Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Helen</u> First <u>A.</u> Middle <u>Halifax</u> Last		4. DATE OF DEATH Month <u>4</u> Day <u>28</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2-21-11</u>
9 AGE (In years last birthday) <u>56</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Iowa</u>
12 CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Henry Lucke</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Knott</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16 SOCIAL SECURTY NO.		17 INFORMANT <u>Mr. Don T. Halifax (same as #2)</u> Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute intracranial hemorrhage</u> DUE TO (b) <u>Essential hypertension</u> DUE TO (c) <u>lost</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			9. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <u>4/28/1967</u>	
23a. BLR A. CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 3, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lakewood Cemetery</u>
23d. LOCATION (City or town) <u>Alcott</u>		(County) <u>New York</u> (State)	
24. FUNERAL DIRECTOR <u>J. Arthur Hall</u> ADDRESS <u>254 Cornell BLVD. Wash DC</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>MAY 1 1967</u>	
25b. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
20 M 1/66

# CERTIFICATE OF DEATH

05356		05354	
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring,</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		d. STREET ADDRESS <b>Kinross</b> <b>10103 Kinross Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Matthew</b> Last <b>Hanlon</b>		4. DATE OF DEATH Month <b>April</b> Day <b>1</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-16-84</b> 9. AGE (In years last birthday) <b>82</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired--Insurance Agent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Louisville, Ky.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Michael Hanlon</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Lyons</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO <b>579-30-2171</b>	
17. INFORMANT <b>William L. Hanlon, Son,</b>		Address <b>403 Lexington Dr. SS</b>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <b>4201</b> (b) <b>Myocardial insufficiency</b> (c) <b>Arteriosclerotic hypertensive cardiovasc. disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b> <b>1 year</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (his hospital) attended the deceased from <b>19 35 to April 1, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 1, 1967</b> , and that death occurred at <b>5 p.m.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Raymond Bradshaw, M.D.</b>		22b. DATE SIGNED <b>4-1-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Raymond Bradshaw</b>		22d. ADDRESS <b>345 University Blvd. W., S. S., Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Apr 5, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Prince Georges Co., Md.</b>
24. FUNERAL DIRECTOR <b>John B. Thomas</b>		25a. REC'D BY REGISTRAR <b>APR 7 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

25c. ADDRESS **8434 Georgia Avenue**  
**Warner E. Pumphrey, Inc. Silver Spring, Md.**



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
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VR A15ME (5)  
6M 1/67

05357

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05355

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON SAN. &amp; HOSP.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>LOWELL (NONE) HARDIN</b>		4 DATE OF DEATH Month Day Year <b>APRIL 18, 1967</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 1, 1917</b>
9 AGE (In years last birthday) <b>50</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <b>50</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED ARMY</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ARMED FORCES</b>	
11 BIRTHPLACE (State or foreign country) <b>ILLINOIS</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>DAVID HARDIN</b>		14 MOTHER'S MAIDEN NAME <b>CORA</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv. etc.) <b>YES WWII + KOREA</b>		16 SOCIAL SECURITY NO <b>315 10 0052</b>	
17 INFORMANT <b>S.S. POLICE &amp; MRS L. HARDIN (WIFE)</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Gunshot wound, upper right chest,</b> DUE TO (b) <b>apparently self-inflicted</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>Deceased in poor health and despondent - shot self with shot gun</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Deceased in poor health and despondent - shot self with shot gun</b>	
20c. TIME OF INJURY Month, Day Year Hour <b>5:40</b> p.m. <b>4 - 18 19 67</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Silver Spring Montg Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Belden R. Read</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BELDEN R. READ M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <b>4/18/1967</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (City, State, County) <b>Washington, D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 21, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR <b>Arthur Walters, 254 Carroll St. N.W. DC</b>		25a. REC'D BY REGISTRAR <b>APR 21 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>James J. Jones</b>		25c. REGISTRAR'S SIGNATURE <b>James J. Jones</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05358

CERTIFICATE OF DEATH

05356

1 PLACE OF DEATH a. COUNTY <u>Mont. Co.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beckwith</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Stu. Beckman</u>		d. STREET ADDRESS <u>4419 - Walnut St.</u>	
3 NAME OF DECEASED (Type or print) <u>McLean E. Haydon</u>		4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/26/90</u>
9 AGE (In years last birthday) <u>76</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stenographer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>govt.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>J.P. East a veson</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Bennett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Charles T. Haydon.</u>		Address <u>  </u>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Peritonitis, acute</u> DUE TO <u>4201</u> (b) <u>Mesenteric thrombosis, massive</u> DUE TO <u>  </u> (c) <u>Arteriosclerosis, severe</u>			INTERVA. BETWEEN ONSET AND DEATH <u>DAYS</u> <u>DAYS</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Infarct myocardial, massive</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3-30</u> , 19 <u>67</u> to <u>4-22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-22</u> , 19 <u>67</u> , and that death occurred at <u>6:25</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Robert G. Brewer</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Robert G. Brewer</u>		22d. ADDRESS <u>8505 Old Georgetown Rd. Bethesda, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-26-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. RECEIVED BY REGISTRAR <u>APR 28 1967</u>	
25b. SIGNATURE <u>  </u>		25c. SIGNATURE <u>  </u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #23c & 1 Film #31-8 57/1/67 pc

05353

CERTIFICATE OF DEATH

05357

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>2725-39th St. N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>J. Donald Henderson</u>				4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/29/09</u>		9. AGE in years (last birthday) <u>57</u> yrs	F UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Scientist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food Science Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles F. Henderson</u>				14. MOTHER'S MAIDEN NAME <u>Louise Siebross</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Hans J. Anderson, 115-5.5th St.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO (b) <u>HEART FAILURE</u> DUE TO (c) <u>PNEUMONIA, BILATERAL</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>SEP</u> , 19 <u>66</u> to <u>APR 17</u> , 19 <u>67</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>APR 17</u> , 19 <u>67</u> , and that death occurred at <u>11:35 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Delwitt E. DeLawter</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Delwitt E. DeLawter MD</u>				22d. ADDRESS <u>3848 PORTER ST NW WASH D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>4-19-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fisher Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Grand Folks, M.D.</u> <u>Fisher, Minn.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>				25a. REC'D BY REGISTRAR <u>DATE APR 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	





FOR STATE  
HEALTH DEPT.

05360

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05358

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if not before admission) a STATE <u>Dist. of Col.</u> b COUNTY <u>Washington</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c LENGTH OF STAY N 1b <u>D.O.A.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San + Hosp.</u>		e STREET ADDRESS <u>1851 Frederick Pl., S.E.</u>	
3 NAME OF DECEASED (Type or print) <u>James Jerry Henson</u>		4 DATE OF DEATH <u>4</u> Month <u>7</u> Day <u>1967</u> Year	
5 SEX <u>M</u>	6 COLOR OR RACE <u>Negro</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>5-31-34</u>
9 AGE (In years last birthday) <u>32</u> yrs		10 IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Dist. of Col.</u>	
11 BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Amos Henson</u>		14 MOTHER'S MAIDEN NAME <u>Josephine Thomas</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>Air Force 51-53 579-48-347</u>		16 SOCIAL SECURITY NO <u>579-48-347</u>	
17 INFORMANT <u>Marjorie Henson</u>		Address <u>203 N St., S.W.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. <u>4a</u> IMMEDIATE CAUSE (a) <u>Acute coronary insufficiency</u> DUE TO (b) <u>Coronary artery heart disease</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour <u>  </u> o m <u>  </u> p m <u>  </u> 19 <u>  </u>	20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e PLACE OF INJURY (Home farm factory street, office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>4/13-67</u>		23b DATE THEREOF <u>4/13-67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>ALEXANDRIA NATIONAL CEMETERY</u>		23d LOCATION (City or town) (County) (State) <u>ALEXANDRIA VA.</u>	
24 FUNERAL DIRECTOR <u>Reap Funeral Home</u>		25a REC'D BY REGISTRAR <u>APR 13 1967</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		22. DATE SIGNED <u>APRIL 7 1967</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

35361

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05359

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. LENGTH OF STAY IN 1b <b>15 YRS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2715 RANDOLPH ROAD</b>				d. STREET ADDRESS <b>2715 RANDOLPH ROAD</b>			
3. NAME OF DECEASED (Type or print) <b>RUTH HELEN HIERLING</b>				4. DATE OF DEATH <b>APRIL 2 1967</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 1, 1922</b>	9. AGE (In years last birthday) <b>44</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>HARVEY DE LONG</b>				14. MOTHER'S MAIDEN NAME <b>ANTOINETTE KAHLERT</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>Yes</b>		17. INFORMANT <b>ROBERT A. HIERLING (HUSBAND)</b> Address (SAME) <b>2715 Randolph Rd. S. S. Md.</b>			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis due to</b> <b>171X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastasis from Carcinoma of</b> DUE TO (c) <b>the Cervix.</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (the hospital) attended the deceased from <b>January 1967</b> to <b>April 2, 1967</b> , that (I) (we) last saw the deceased alive on <b>March 15, 1967</b> , and that death occurred at <b>8:25 PM</b> , from the causes and on the date stated above							
22a. SIGNATURE <b>Belden R. Reap</b> M.D.				22b. DATE <b>APRIL 3, 1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>BELDEN R. REAP, M.D.</b>				22d. ADDRESS <b>Wheaton, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr 5, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Silver Spring, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey, Inc.</b> Address <b>8434 Georgia Avenue Silver Spring, Md.</b>				25a. REC'D BY REGISTRAR <b>APR 7 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



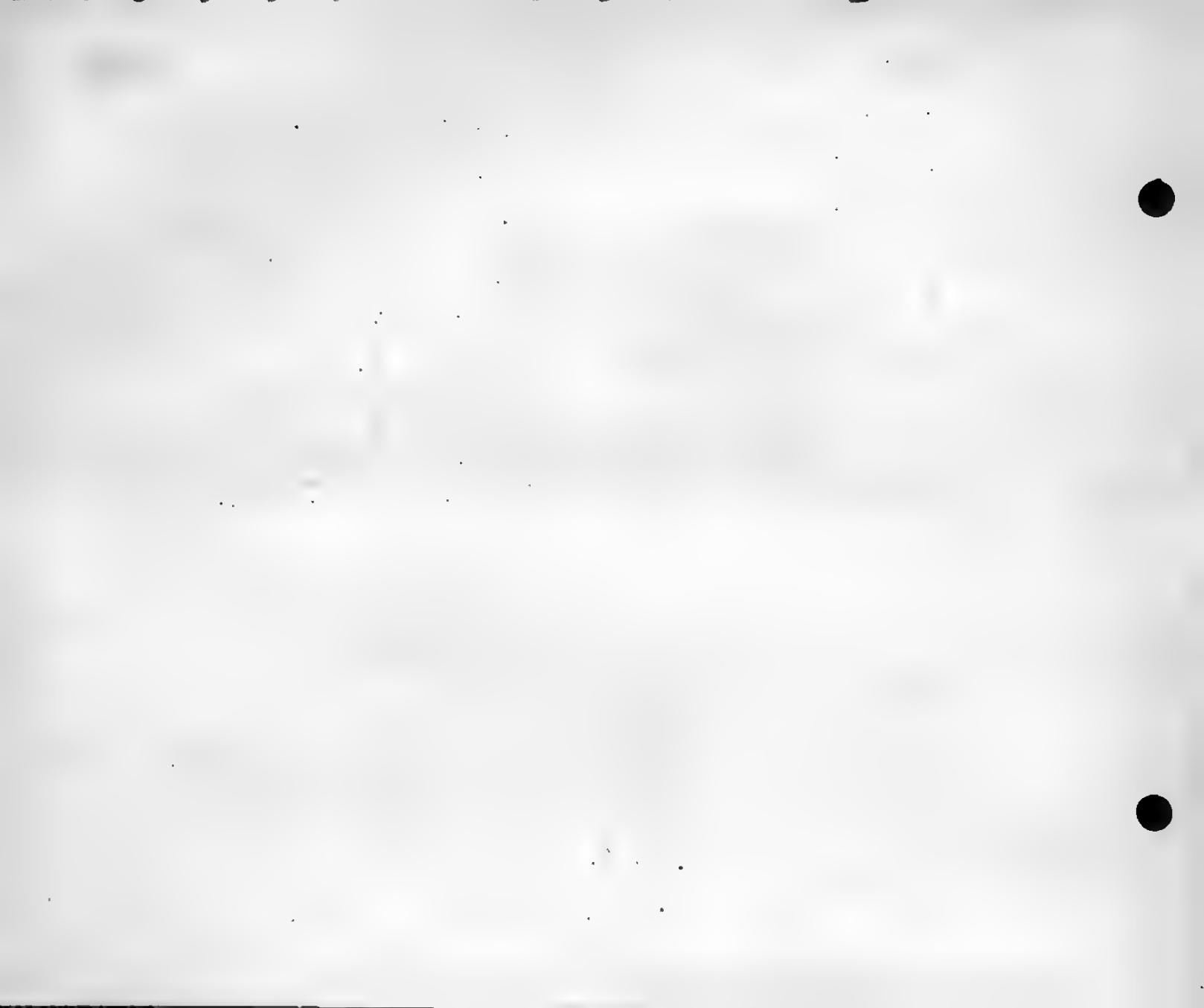
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A156 (5)  
5M 1/65

<div> <div>1</div> <div> <div>FOR STATE HEALTH DEPT.</div> </div> </div> <div> <div> <div>05362</div> <div>05360</div> </div> <div> <div> <div>1. PLACE OF DEATH</div> <div>a. COUNTY</div> </div> <div> <div> <div>Montgomery</div> <div>MARYLAND</div> </div> <div> <div> <div>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>Silver Spring</div> </div> <div> <div> <div>c. LENGTH OF STAY in 1b</div> <div>Occasional</div> </div> <div> <div> <div>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)</div> <div>Holy Cross Hosp - Silver Spring</div> </div> <div> <div> <div>2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)</div> <div>a. STATE</div> </div> <div> <div> <div>b. COUNTY</div> <div>Montgomery</div> </div> <div> <div> <div>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>Wheaton</div> </div> <div> <div> <div>d. STREET ADDRESS</div> <div>2610 Weller Rd</div> </div> <div> <div> <div>e. IS RESIDENCE ON A FARM?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div> </div> </div> </div> </div> </div> </div> </div> <div> <div> <div>3. NAME OF DECEASED (Type or print)</div> <div>First Middle Last</div> <div>Catherine O. Higgins</div> </div> <div> <div>4. DATE OF DEATH</div> <div>Month Day Year</div> <div>April 20 1987</div> </div> </div> <div> <div>5. SEX</div> <div>F</div> <div>6. COLOR OR RACE</div> <div>W</div> <div>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></div> <div>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div> <div>8. DATE OF BIRTH</div> <div>6/14/29</div> <div>9. AGE (In years last birthday)</div> <div>37 yrs.</div> <div>IF UNDER 1 YEAR</div> <div>Months Days Hours Min.</div> </div> <div> <div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>Housewife</div> <div>10b. KIND OF BUSINESS OR</div> <div>AT HOME</div> <div>11. BIRTHPLACE (State or foreign country)</div> <div>WASH., D.C.</div> <div>12. CITIZEN OF WHAT COUNTRY?</div> <div>U.S.A.</div> </div> <div> <div>13. FATHER'S NAME</div> <div>LOUIS L. COLLIE</div> <div>14. MOTHER'S MAIDEN NAME</div> <div>EMMA V. HATCHER</div> </div> <div> <div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)</div> <div>NO</div> <div>16. SOCIAL SECURITY NO.</div> <div>229-34-3694</div> <div>17. INFORMANT</div> <div>Address</div> <div>MONTGOMERY E. HIGGINS - SAME AS #2</div> </div> <div> <div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a)</div> <div>4301</div> <div>DUPLICATE</div> <div>MASSIVE CORONARY THROMBOSIS</div> <div>INTERVAL BETWEEN ONSET AND DEATH</div> <div>2 hr.</div> <div>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</div> <div>DUPLICATE</div> <div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</div> <div>None</div> <div>19. WAS AUTOPSY PERFORMED?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div> </div> <div> <div>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</div> <div>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</div> <div>20c. TIME OF INJURY Month, Day, Year</div> <div>Hour a.m. p.m.</div> <div>19</div> <div>20d. INJURY OCCURRED</div> <div>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></div> <div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div> <div>20f. (City or town) (County) (State)</div> </div> <div> <div>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></div> <div>ACTUAL SIGNATURE</div> <div>John S. Rogers, MD</div> <div>EXAMINER'S NAME (Type)</div> <div>John S. Rogers, MD</div> <div>22. DATE SIGNED</div> <div>4-20-87</div> </div> <div> <div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>BURIAL</div> <div>23b. DATE THEREOF</div> <div>4/24/67</div> <div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>MT. COMFORT CEM.</div> <div>23d. LOCATION (City, town or county) (State)</div> <div>ALEXANDRIA, VA.</div> </div> <div> <div>24. FUNERAL DIRECTOR</div> <div>JOS. CRAWLER'S SONS, 5130 WIS. AVE., N.W., WASHINGTON, D.C.</div> <div>25a. REC'D BY REGISTRAR</div> <div>APR 26 1967</div> <div>25b. REGISTRAR'S SIGNATURE</div> <div>Charles Judge</div> </div> </div></div></div></div></div>											
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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05363

05361

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Mont. Co.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>1230 - Queen St. N.E.</u>	
3 NAME OF DECEASED (Type or print) <u>Thorothy B. Hines</u>		4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1967</u>	
5 SEX <u>female</u>	6 COLOR OR RACE <u>negro</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2-28-26</u>
9 AGE (Years lost birthday) <u>41</u> yrs		10 IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>nursing assist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>	
11 BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Sylvester Cole</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Davis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-32-2759</u>	
17. INFORMANT <u>John Hines-husband</u>		Address <u>1230 Queen St</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>824.4 Pulmonary Embolism. Massive Rt Long</u> DUE TO (b) <u>Thrombosis of Veins of Left Leg</u> DUE TO (c) <u>Trauma of Left leg.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>days?</u> <u>5 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Fell getting off bus - and strained left ankle</u>	
20c. TIME OF INJURY Month, Day, Year <u>8:50 - 3/11 1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) <u>Street -</u>
20f. (City or town) (County) (State) <u>Washington - DC -</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John B. Bell</u> M.D.		22. DATE SIGNED <u>4/17/67</u>	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)			
23a. BURIAL CREMATION REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>Burial</u>	<u>4/24/67</u>	<u>Lincoln Memorial Ceme.</u>	<u>Maryland</u>
24. FUNERAL DIRECTOR <u>John T. Stewart</u>		25a. REC'D BY REGISTRAR <u>APR 20 1967</u>	
Stewart Funeral Home-4001 Benning Rd.,		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05364

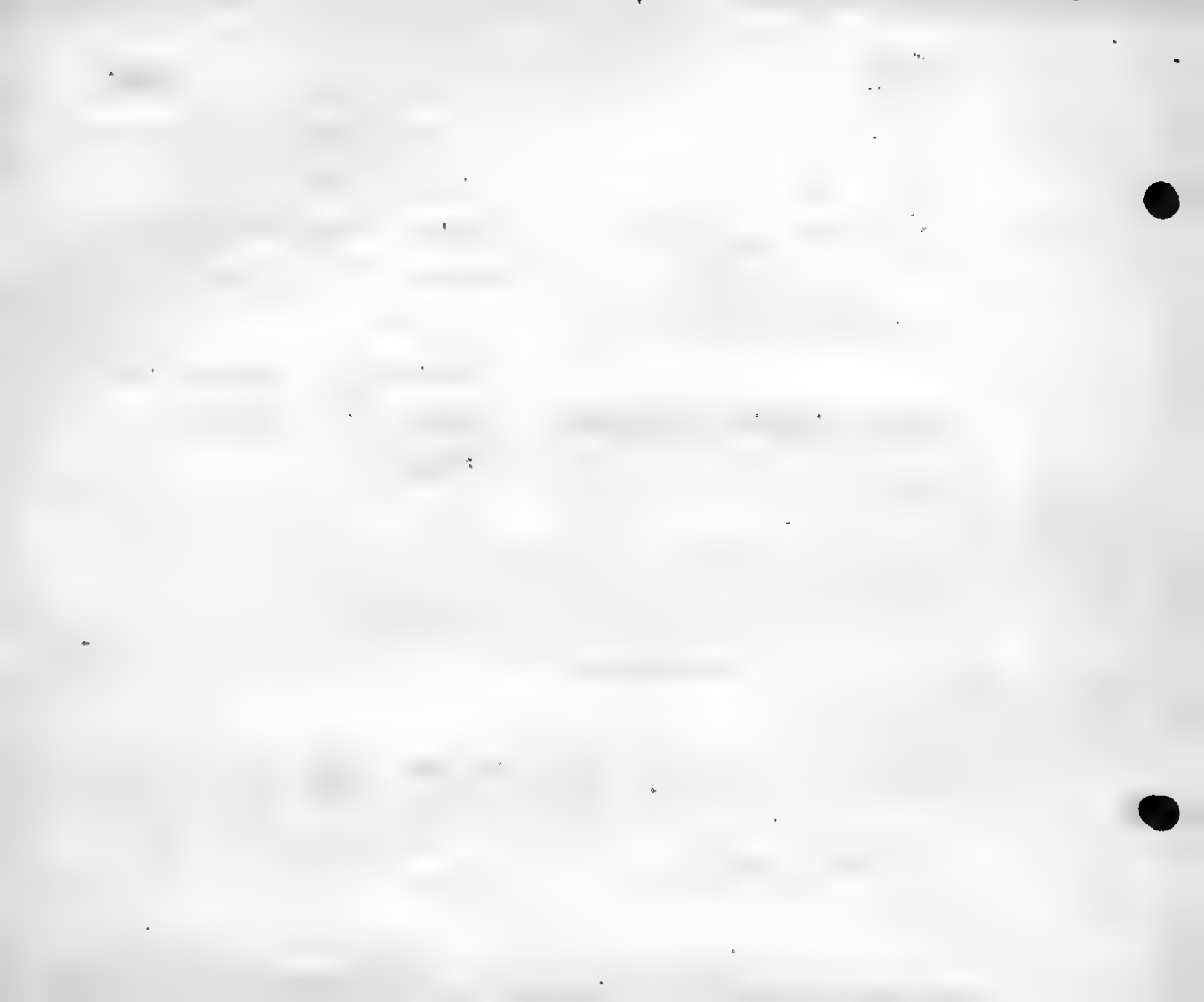
## CERTIFICATE OF DEATH

05362

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross</u>		d. STREET ADDRESS <u>4407 Independence St.</u>	
3. NAME OF DECEASED (Type or print) <u>Hodgdon</u>		4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-16-67</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs <u>13</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Harrison Hodgdon</u>		14. MOTHER'S MAIDEN NAME <u>Ruby Lee Hamn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Father</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Term Birth, NEONATAL DEATH</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>FETAL Anoxia</u> DUE TO (c) <u>Ruptured Uterus</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-16</u> , 19 <u>67</u> , to <u>4-16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-16</u> , 19 <u>67</u> , and that death occurred at <u>11:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Brockett Muir</u> M.D.		22b. DATE SIGNED <u>April 17 '67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Brockett Muir</u>		22d. ADDRESS <u>Georgetown Doctors Park Cedar Lane, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/21/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Md.</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1331 Rockville Pike</u> ADDRESS <u>Rockville, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 24 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



05365

## CERTIFICATE OF DEATH

05363

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>37 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marion Station</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>		d. STREET ADDRESS <b>Box 199-E, Route 1</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <b>Donald</b> Middle <b>Curtis</b> Last <b>Holden</b>		4. DATE OF DEATH Month <b>April</b> Day <b>7</b> Year <b>19 67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12 January 1950</b>
9 AGE (In years last birthday) <b>17 yrs</b>		IF UNDER 1 YEAR Months <b>17</b> Days <b>17</b>	IF UNDER 24 HRS Hours <b>17</b> Min. <b>17</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Earl C. Holden</b>	
14. MOTHER'S MAIDEN NAME <b>Tyvoila Handy</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16 SOCIAL SECURITY NO <b>212-56-1099</b>		17. INFORMANT <b>The Medical Record</b> <b>The Clinical Center, Bethesda, Maryland</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Pancytopenia</b> DUE TO (c) <b>Reticulum Cell Sarcoma</b>			INTERVAL BETWEEN ONSET AND DEATH <b>14 Days</b> <b>5 Weeks</b> <b>9 Months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1 March</b> , 19 <b>67</b> , to <b>7 April</b> , 19 <b>67</b> , that (I) (we) lost the deceased on <b>7 April</b> , 19 <b>67</b> , and that death occurred at <b>7:00 M.</b> , from causes on and on the date stated above.			
22a. SIGNATURE <i>Myron J. Levin</i>		22b. DATE SIGNED <b>8 April 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Myron J. Levin, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/10/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MARYMESC</b>	23d. LOCATION (City or Town) (County) (State) <b>MARYMESC</b>
24. FUNERAL DIRECTOR <i>Anthony E. Ware</i>		25. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

35366

## CERTIFICATE OF DEATH

05364

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN lb <u>1 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Muncaster Mill Rd.</u>		d. STREET ADDRESS <u>none</u>	
3. NAME OF DECEASED (Type or print) <u>Revelyn Jean</u> First <u>Joan</u> Middle <u>Hollander</u> Last <u>Hollander</u>		4. DATE OF DEATH <u>22 April</u> 19 <u>67</u> Month <u>April</u> Day <u>22</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 3, 1924</u> 42 yrs
9. AGE (In years last birthday) <u>42</u>		10. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> 2 YEARS <input type="checkbox"/> 3 YEARS <input type="checkbox"/> 4 YEARS <input type="checkbox"/> 5 YEARS <input type="checkbox"/> 6 YEARS <input type="checkbox"/> 7 YEARS <input type="checkbox"/> 8 YEARS <input type="checkbox"/> 9 YEARS <input type="checkbox"/> 10 YEARS <input type="checkbox"/> 11 YEARS <input type="checkbox"/> 12 YEARS <input type="checkbox"/> 13 YEARS <input type="checkbox"/> 14 YEARS <input type="checkbox"/> 15 YEARS <input type="checkbox"/> 16 YEARS <input type="checkbox"/> 17 YEARS <input type="checkbox"/> 18 YEARS <input type="checkbox"/> 19 YEARS <input type="checkbox"/> 20 YEARS <input type="checkbox"/> 21 YEARS <input type="checkbox"/> 22 YEARS <input type="checkbox"/> 23 YEARS <input type="checkbox"/> 24 YEARS <input type="checkbox"/> 25 YEARS <input type="checkbox"/> 26 YEARS <input type="checkbox"/> 27 YEARS <input type="checkbox"/> 28 YEARS <input type="checkbox"/> 29 YEARS <input type="checkbox"/> 30 YEARS <input type="checkbox"/> 31 YEARS <input type="checkbox"/> 32 YEARS <input type="checkbox"/> 33 YEARS <input type="checkbox"/> 34 YEARS <input type="checkbox"/> 35 YEARS <input type="checkbox"/> 36 YEARS <input type="checkbox"/> 37 YEARS <input type="checkbox"/> 38 YEARS <input type="checkbox"/> 39 YEARS <input type="checkbox"/> 40 YEARS <input type="checkbox"/> 41 YEARS <input type="checkbox"/> 42 YEARS <input type="checkbox"/> 43 YEARS <input type="checkbox"/> 44 YEARS <input type="checkbox"/> 45 YEARS <input type="checkbox"/> 46 YEARS <input type="checkbox"/> 47 YEARS <input type="checkbox"/> 48 YEARS <input type="checkbox"/> 49 YEARS <input type="checkbox"/> 50 YEARS <input type="checkbox"/> 51 YEARS <input type="checkbox"/> 52 YEARS <input type="checkbox"/> 53 YEARS <input type="checkbox"/> 54 YEARS <input type="checkbox"/> 55 YEARS <input type="checkbox"/> 56 YEARS <input type="checkbox"/> 57 YEARS <input type="checkbox"/> 58 YEARS <input type="checkbox"/> 59 YEARS <input type="checkbox"/> 60 YEARS <input type="checkbox"/> 61 YEARS <input type="checkbox"/> 62 YEARS <input type="checkbox"/> 63 YEARS <input type="checkbox"/> 64 YEARS <input type="checkbox"/> 65 YEARS <input type="checkbox"/> 66 YEARS <input type="checkbox"/> 67 YEARS <input type="checkbox"/> 68 YEARS <input type="checkbox"/> 69 YEARS <input type="checkbox"/> 70 YEARS <input type="checkbox"/> 71 YEARS <input type="checkbox"/> 72 YEARS <input type="checkbox"/> 73 YEARS <input type="checkbox"/> 74 YEARS <input type="checkbox"/> 75 YEARS <input type="checkbox"/> 76 YEARS <input type="checkbox"/> 77 YEARS <input type="checkbox"/> 78 YEARS <input type="checkbox"/> 79 YEARS <input type="checkbox"/> 80 YEARS <input type="checkbox"/> 81 YEARS <input type="checkbox"/> 82 YEARS <input type="checkbox"/> 83 YEARS <input type="checkbox"/> 84 YEARS <input type="checkbox"/> 85 YEARS <input type="checkbox"/> 86 YEARS <input type="checkbox"/> 87 YEARS <input type="checkbox"/> 88 YEARS <input type="checkbox"/> 89 YEARS <input type="checkbox"/> 90 YEARS <input type="checkbox"/> 91 YEARS <input type="checkbox"/> 92 YEARS <input type="checkbox"/> 93 YEARS <input type="checkbox"/> 94 YEARS <input type="checkbox"/> 95 YEARS <input type="checkbox"/> 96 YEARS <input type="checkbox"/> 97 YEARS <input type="checkbox"/> 98 YEARS <input type="checkbox"/> 99 YEARS <input type="checkbox"/> 100 YEARS <input type="checkbox"/>	
11. BIRTHPLACE (County & State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Holland</u>		14. MOTHER'S MAIDEN NAME <u>Ethel Winslow</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS A TOLPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1, 1966</u> to <u>April 17, 1967</u> , that (I) (we) last saw the deceased alive on <u>22 April 1967</u> and that death occurred at <u>5 P.</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>R. Butler</u>		22b. DATE SIGNED <u>22 April 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. Butler</u>		22d. ADDRESS <u>2710 Norbeck Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Apr. 27, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Sandy Spring, Md.</u>
24. FUNERAL DIRECTOR <u>Robert L. Snowden</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Rockville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



95367

## CERTIFICATE OF DEATH

05365

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 1b <i>17 hrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton, Md.</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hospital</i>				d. STREET ADDRESS <i>University Housing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Marie</i> Middle <i>T.</i> Last <i>Holloway</i>		4. DATE OF DEATH Month <i>4</i> Day <i>9</i> Year <i>1967</i>					
5. SEX <i>+</i>	6. COLOR OR RACE <i>negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/2/1890</i>	9. AGE (In years lost birthday) <i>76 yrs.</i>	IF UNDER 1 YEAR Months <i>7</i> Days <i>6</i>	IF UNDER 24 HRS. Hours <i>17</i> Min. <i>00</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>No. CAROLINA</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>WILLIAM TATE</i>				14. MOTHER'S MAIDEN NAME <i>EMMA ?</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT <i>VIVIAN T. BGGG</i>		Address <i>6717-13 PLACE, N.W.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Pulmonary Edema &amp; CVA.</i> DUE TO (b) <i>Atherosclerotic Cardiovascular Disease</i> DUE TO (c) <i>Old age.</i>						INTERVAL BETWEEN ONSET AND DEATH <i>approx 5, 14 hr.</i> <i>simultaneous.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic Lung Disease</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <i>a.m.</i> <i>19</i>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Apr. 7, 1967</i> to <i>Apr. 9, 1967</i> , that (I) (we) last saw the deceased alive on <i>Apr. 9, 1967</i> , and that death occurred at <i>5 PM</i> , from causes and on the date stated above.							
22a. SIGNATURE <i>R. C. Bufalino</i>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>Apr 10, 1967</i>	
22c. PHYSICIAN'S NAME (Type) <i>R. C. BUFALINO, M.D.</i>				22d. ADDRESS <i>1429 University Blvd NW Silver Spring</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>4-12-1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>VIOLET HILL</i>		23d. LOCATION (City or Town) (County) (State) <i>ASHVILLE, N.C.</i>	
24. FUNERAL DIRECTOR <i>W. ERNEST LARVIN CO.</i>		ADDRESS <i>1432 Yew St. NW</i>		25a. REC'D BY REGISTRAR <i>APR 13 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. [Signature]</i>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Heard by Medical Officers





05368

CERTIFICATE OF DEATH

05366

1 PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Pennsylvania		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 100 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Enterprise			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Md. 20014				d. STREET ADDRESS R.D. # 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Cheryl		First Middle Last Aileen Holt		4. DATE OF DEATH April 21 1967			
5 SEX Female	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6 October 1945		9 AGE (In years last birthday) 21 yrs	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (County & State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Kenneth P. Holt				14. MOTHER'S MAIDEN NAME Helen Cogan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO. Not available		17. INFORMANT The Medical Records Address The Clinical Center, Bethesda, Maryland 20014			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchiectasis</u> DUE TO (c) <u>Cystic fibrosis</u>						INTERVAL BETWEEN ONSET AND DEATH 10 minutes unknown since birth	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (s) (this hospital) attended the deceased from Jan. 11, 1967, to April 21, 1967, that (s) (we) last saw the deceased alive on April 21, 1967, and that death occurred at 10:45M, from causes and on the date stated above.							
22a. SIGNATURE David N. Soghor		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED April 22, 1967			
22c. PHYSICIAN'S NAME (Type) David N. Soghor, M.D.		22d ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 4/25/67		23c. NAME OF CEMETERY OR CREMATORY Grandview Cemetery		23d LOCATION (City or Town) (County) (State) Altoona, Pennsylvania	
24. FUNERAL DIRECTOR Wynson Heeler Funeral Home-1331 Rockville Pike Rockville, Md.		ADDRESS		25a REC'D BY REGISTRAR APR 25 1967		25b REGISTRAR'S SIGNATURE J. Charles Judge	

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05369

## CERTIFICATE OF DEATH

05367

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Virginia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN 1b <b>22 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		d. STREET ADDRESS <b>903 Essex Drive</b>	
3 NAME OF DECEASED (Type or print) <b>Vaughn Erland HOLT</b>		4 DATE OF DEATH Month <b>April</b> Day <b>27</b> Year <b>19 67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>1927</b> <b>December 11,</b>
9 AGE (In years lost birthday) <b>40 39 yrs</b>		10 IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) <b>Iowa</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jess Holt</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Martin</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes 1946-1964</b>		16. SOCIAL SECURITY NO. <b>335 24 2001</b>	
17. INFORMANT <b>Mrs. Gladys Holt, 903 Essex Drive</b>		Address <b>Virginia</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HODGKINS DISEASE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that <del>it</del> (this hospital) attended the deceased from <b>Apr. 6</b> , 19 <b>67</b> , to <b>Apr. 27</b> , 19 <b>67</b> , that <del>it</del> (we) last saw the deceased alive on <b>Apr. 27</b> , 19 <b>67</b> , and that death occurred at <b>1125 P.M.</b> , from causes on and on the date stated above.			
22a. SIGNATURE <b>R. J. Kinney</b>		22b. DATE SIGNED <b>APRIL 29, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>R. J. KINNEY</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5-2-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington Virginia</b>
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey Funeral Home</b> <b>7557 Wisconsin Ave., Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>DATE MAY 3 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

05370

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05368

1 PLACE OF DEATH a COUNTY <b>Mpntgpmery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admiss on) a STATE <b>Virginia</b> b COUNTY <b>Fairfax</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c LENGTH OF STAY IN lb <b>D.O.A.</b>	
d NAME OF HOSPITAL OR INSTITUT ON (If not in hospital, give street address) <b>Holy Cross Hospital</b>		d STREET ADDRESS <b>123 South Lee Street</b>	
3 NAME OF DECEASED (Type or print) First <b>Emil</b> Middle <b>Frederick</b> Last <b>Holtz</b>		4. DATE OF DEATH Month <b>April</b> Day <b>7</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>December 4, 1930</b>
9 AGE (In years last birthday) <b>36</b> yrs		10 IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min	
11 BIRTHPLACE (State or foreign country) <b>Pittsburg, Penna.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Emil E. Holtz</b>		14. MOTHER'S MAIDEN NAME <b>Sarah King</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>		16 SOCIAL SECURITY NO	
17 INFORMANT <b>Beglinger Funeral Home</b>		Address <b>1008 Chartiers Ave. Pittsburg, Pa.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute, extreme, multiple</b> 174 DUE TO <b>Fractures of skull with</b> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last <b>exsanguination</b> DUE TO (b) DUE TO (c) <b>exsanguination</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTR BLTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COND TION GIVEN IN PART I(a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Deceased, driver of truck, struck over-pass support on Rte 495 near Pa. Ave.</b>	
20c TIME OF INJURY Month, Day, Year <b>342 4-7 19 67</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) <b>Beltway Rte 495</b>		20f City or town (County) (State) <b>Silver Spring Montgomery Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Belden R. Reap</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BELDEN R. REAP M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <b>April 7, 1967</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Trans-burial</b>		23b DATE THEREOF <b>Apr 11, 1967</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Baldwin Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Pittsburg, Penna.</b>	
24. FUNERAL DIRECTOR <b>C. Glen Carter</b>		ADDRESS <b>8434 Georgia Avenue</b>	
25a REC'D BY REGISTRAR <b>APR 11 1967</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



05371

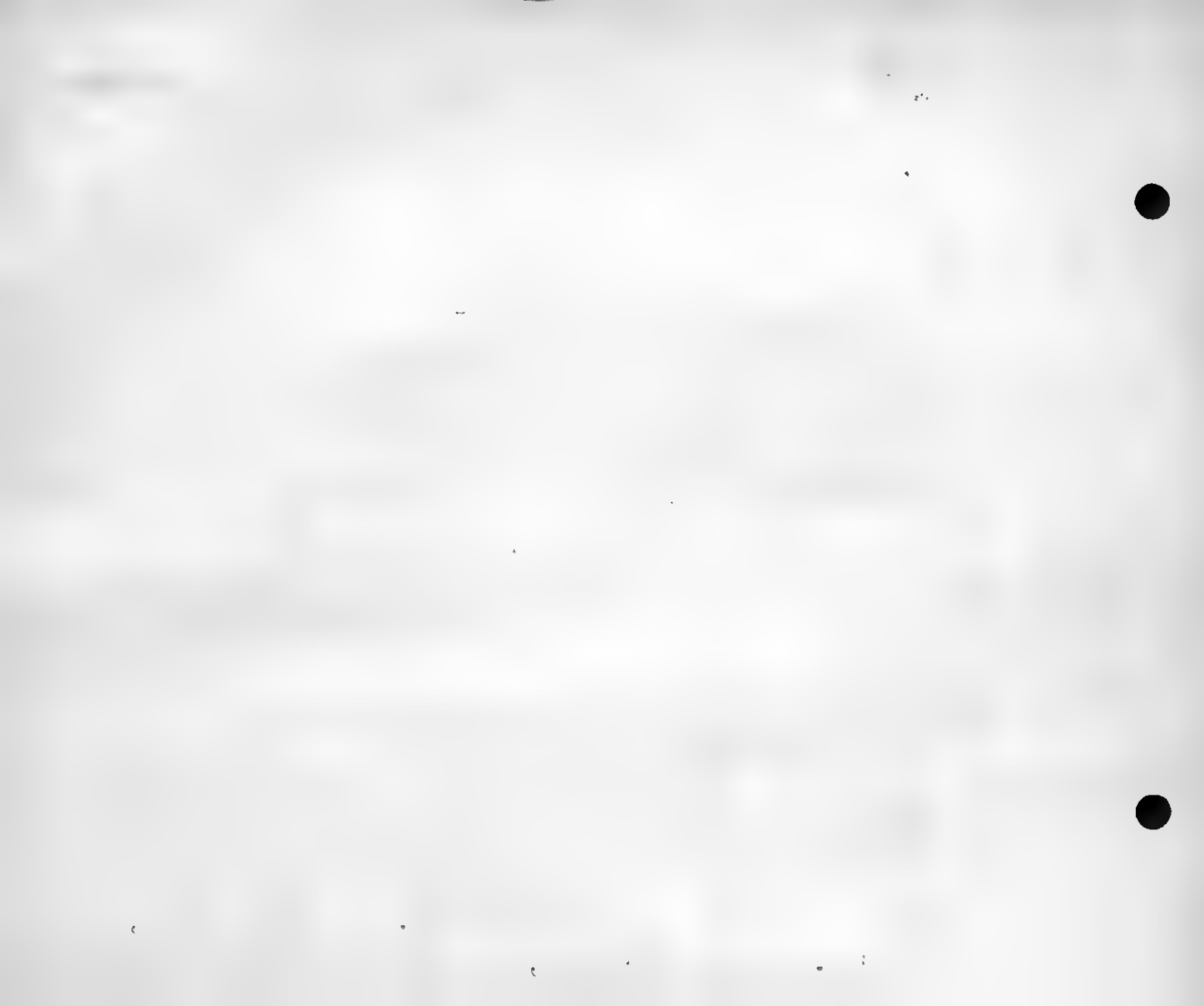
## CERTIFICATE OF DEATH

05369

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ednor</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>		d. STREET ADDRESS <b>151</b>	
3. NAME OF DECEASED (Type or print) <b>William</b> First <b>Arthur</b> Middle <b>H</b> Last <b>ood</b>		4. DATE OF DEATH Month <b>April</b> Day <b>26</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-18-98</b>
9. AGE (In years last birthday) <b>69</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Post Office</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Charles R. Hood</b>		14. MOTHER'S MAIDEN NAME <b>Martha Fuller</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes give war or dates of service)</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Address</b>			
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Pulmonary Embolism</b> DUE TO <b>8 hr. post-op Leg Amputation</b> (b) <b>Arteriosclerosis Obliterans</b> DUE TO <b>years</b> (c) <b>years</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Nephrosclerosis</b> <b>Latent Diabetes Mellitus</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. Certify that (I) (this hospital) attended the deceased from <b>1947</b> , 19 <b>Jun 26</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>Jun 26</b> 19 <b>67</b> , and that death occurred at <b>3:10 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Richard A. Yates M.D.</b> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>4/26/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>RICHARD A. YATES, M. D.</b>		22d. ADDRESS <b>OLNEY, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/29/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sandy Spring Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Sandy Spring, Md</b>
24. FUNERAL DIRECTOR <b>Robert L. Snowden</b> ADDRESS <b>Rockville, Md</b>		25a. REC'D BY REGISTRAR <b>MAY 2 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

(M)

05372

05370

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5600 SPRINGFIELD DRIVE</b>				d. STREET ADDRESS <b>5600 SPRINGFIELD DRIVE</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ANNA MARIE HOPKINS</b>				4. DATE OF DEATH Month Day Year <b>April 21 1967</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 2, 1902</b>	
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (County & State, or foreign country) <b>IRELAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Retired Nurse</b>			
13. FATHER'S NAME <b>AUSTIN CLANCY SR.</b>				14. MOTHER'S MAIDEN NAME <b>MARY HAYES</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO <b>578-56-8024</b>		17. INFORMANT <b>Dr. Gerald A. Hopkins</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of lung</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>10 yrs</b> DUE TO (c) <b>13 mos.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>13 mos.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>—</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>—</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March, 1966</b> , to <b>April 21, 1967</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>April 20, 1967</b> , and that death occurred at <b>4 A.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>E. W. Nicklas M.D.</b>				22b. DATE SIGNED <b>4/21/67</b>		22c. PHYSICIAN'S NAME (Type) <b>E. W. NICKLAS</b>	
22d. ADDRESS <b>4830 - V St. N.W. Wash. D.C.</b>				22e. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/24/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery Silver Spring</b>		23d. LOCATION (City or Town) (County) (State) <b>Montgomery Md.</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons 5130 Wisc. Ave. N.W.</b>				25a. REC'D BY REGISTRAR <b>APR 26 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05373

## CERTIFICATE OF DEATH

05371

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> c. LENGTH OF STAY IN 1b <b>Washington, D.C.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Carroll Hall Sanitarium 10231 Carroll Place</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Washington, D.C.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b> d. STREET ADDRESS <b>4133 New Hampshire Ave.</b> e. IS RESIDENCE ON A FARM? Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>Frank</b> Last <b>HORTMAN</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>18</b> Year <b>1967</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/26/85</b>	
9. AGE (in years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months <b>8</b> Days <b>18</b>		IF UNDER 24 HRS. Hours <b>18</b> Min. <b>00</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plate printer Bureau of Printing &amp; Engraving</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plate printer Bureau of Printing &amp; Engraving</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Printing &amp; Engraving</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Stewart Hortman</b>				14. MOTHER'S MAIDEN NAME <b>Louella Metz</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>578-52-4235</b>		17. INFORMANT <b>Nellie I. Hortman same as #2</b> Address			
MEDICAL CERTIFICATION						18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (b) <b>ESSENTIAL HYPERTENSION</b> DUE TO (c) <b>GENERALIZED ARTERIOSCLEROSIS</b>	
						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
						20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>SENILITY</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>APRIL 12, 1966</b> , to <b>APRIL 18, 1967</b> , that (I) (we) last saw the deceased alive on <b>APRIL 18, 1967</b> ; and that death occurred at <b>10:12 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Henry M. Lowden</b>				22b. DATE SIGNED <b>APRIL 18 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>Henry M. Lowden</b>	
22d. ADDRESS <b>5206 N. ...</b>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ATTENDING PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>4/20/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR <b>The S.H. Hines Co.</b>				25a. REC'D BY REGISTRAR <b>APR 20 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards, papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05374

CERTIFICATE OF DEATH

05372

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>6 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>4005 Plym. mill Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lalburn</u> First Middle Last <u>Howard</u>				4. DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>1967</u>			
5. SEX <u>m</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/30/186</u>	
9. AGE (In years last birthday) <u>80</u> yrs		IF UNDER 1 YEAR Months Days Hours Min		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>Milton Howard</u>		14. MOTHER'S M maiden NAME <u>i. Ullie ?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Elsie Outlaw Eastern Ave</u> Address <u>16005</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY ATHEROSCLEROSIS</u> DUE TO (c) <u>UNKNOWN</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Was 4-5 hrs</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour 'a.m. 'p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>APRIL 28</u> , 19 <u>67</u> , to <u>APRIL 28</u> , 19 <u>67</u> , that (I) (we) lost the deceased alive on <u>APRIL 28</u> , 19 <u>67</u> , and that death occurred at <u>1:31 A.M.</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Edward A. Beeman</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>APRIL 29, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD A. BEE MAN</u>				22d. ADDRESS <u>1015 SPRING ST. SILVER SPRING MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 3 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial</u>		23d. LOCATION (City or town) (County) (State) <u>Sandy Spring Mont. Md.</u>	
24. FUNERAL DIRECTOR <u>Robert L. Snader</u>				ADDRESS <u>Rachael</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>MAY 5 1967</u>							



05375

## CERTIFICATE OF DEATH

05373

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>		d. STREET ADDRESS <u>13313 Wye Oak Drive, Route 3</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Charles Howarth</u>		4. DATE OF DEATH Month Day Year <u>April 5 19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 3, 1931</u>
9. AGE (In years lost birthday) <u>36 yrs</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Building Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Earl R. Howarth</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Grant</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>1948-1952</u>		16. SOCIAL SECURITY NO. <u>Not available</u>	
17. INFORMANT <u>The Medical Records</u>		Address <u>The Clinical Center, Bethesda, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Acute Myelogenous Leukemia</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>22 hours</u> <u>4 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <u>XII</u> (this hospital) attended the deceased from <u>April 1</u> , 19 <u>67</u> , to <u>April 5</u> , 19 <u>67</u> , that <u>(X)</u> (we) last saw the deceased alive on <u>April 5</u> , 19 <u>67</u> , and that death occurred at <u>5:25 PM</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>Jerry L. Spivak</u>		22b. DATE SIGNED <u>6 April 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Jerry L. Spivak, M.D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/8/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Darnestown Church Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Darnestown, Maryland</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1331 Rockville Pike</u> <u>Rockville, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 7 1967</u>	25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

(M)

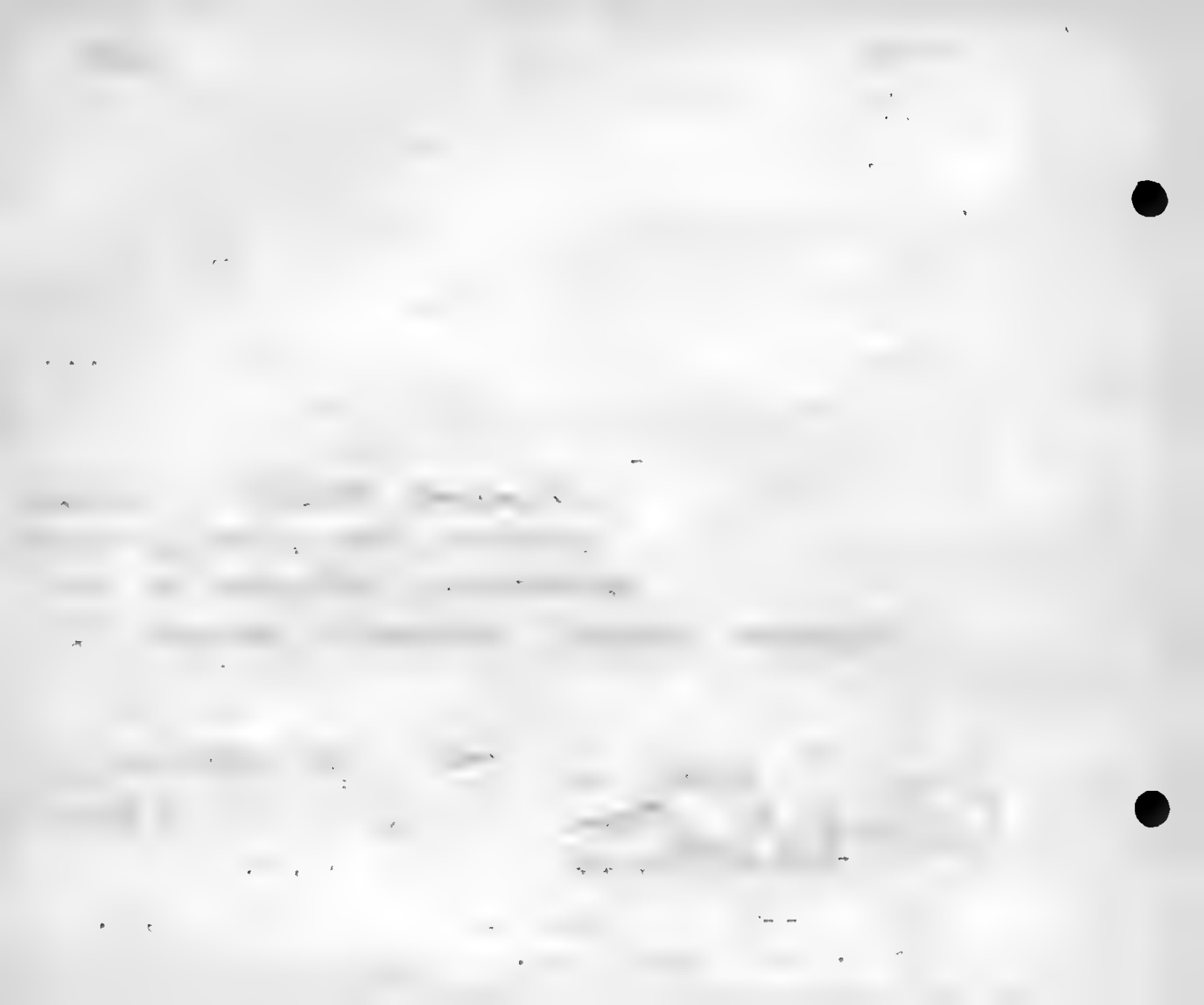
05376

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05374

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c LENGTH OF STAY IN 1b <b>26 days</b>	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Spencerville</b>
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>		d STREET ADDRESS <b>16000 Batson Road</b>	e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) <b>Leonard Samuel Howes</b>		4 DATE OF DEATH Month <b>April</b> Day <b>2</b> Year <b>19 67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>5/6/14</b>
9. AGE (In years last birthday) yrs. <b>52</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>Repairman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bottling Company</b>	11. BIRTHPLACE (Country & State, or foreign country) <b>Maryland</b>
12 CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13 FATHER'S NAME <b>Samuel Howes</b>		14 MOTHER'S MAIDEN NAME <b>Grace Howes</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO <b>-</b>	17 INFORMANT <b>Hospital Records</b> Address
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY <b>443X</b> IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b> DUE TO (b) <b>UREMIA - CHRONIC RENAL DYSF</b> DUE TO (c) <b>HYPERTENSIVE CARDIOVASC. DIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b> <b>5 YRS</b> <b>YRS.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CEREBRAL EDEMA: METABOLIC ACIDOSIS</b>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>FEB.</b> 1964, to <b>2 APRIL 1967</b> , that (1) (we) last saw the deceased alive on <b>3 APRIL 1967</b> , and that death occurred at <b>1:30 PM</b> from causes and on the date stated above.			
22a SIGNATURE <b>Donald R. Lewis</b> 22c. PHYSICIAN'S NAME (Type) <b>D. R. LEWIS</b> <b>Frederick Moomau, M.D.</b>		22b. DATE SIGNED <b>3 APRIL '67</b>	22d. ADDRESS <b>Sandy Spring, Md.</b>
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4-5-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Burtonsville</b>	23d LOCATION (City or Town) (County) (State) <b>Burtonsville, Md.</b>
24. FUNERAL DIRECTOR <b>Francis H. Barber</b> <b>Laytonsville, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 4 1967</b>	25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

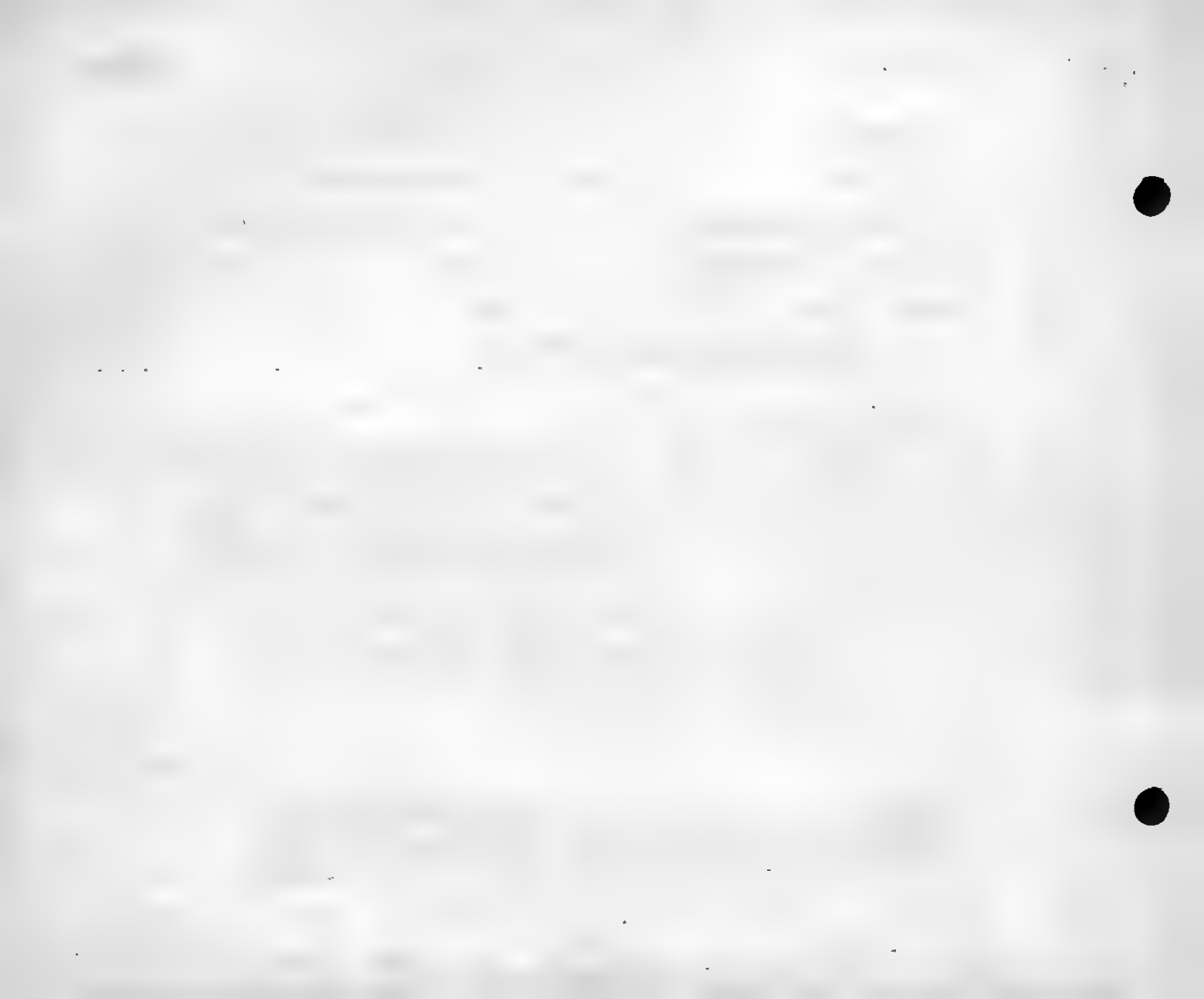
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05377

CERTIFICATE OF DEATH

05375

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>5 years</u>		2. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
3. NAME OF DECEASED (Type or print) <u>Catherine</u> First Middle Last <u>Hudson</u>		4. DATE OF DEATH Month Day Year <u>April 30 19 67</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 9, 1898</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Trimming Operator Bureau of Print.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Engraving</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George L. Yoe</u>		14. MOTHER'S MAIDEN NAME <u>Emma Mahaney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-56-0526 A</u>	
17. INFORMANT <u>Bernard A. Hudson</u>		Address <u>2111 Hildarose Drive Silver Spring, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>4 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Rheumatoid Arthritis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 1, 1966</u> to <u>April 30, 1967</u> that (I) (we) last saw the deceased alive on <u>April 30, 1967</u> and that death occurred at <u>9 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John J. Curry</u>		22b. DATE SIGNED <u>4/30/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John J. Curry</u>		22d. ADDRESS <u>10620 Georgia Ave S.S. Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>May 3, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Forest Glen, Maryland</u>
24. FUNERAL DIRECTOR <u>John B. Warner &amp; Son, Inc.</u>		25a. REC'D BY REGISTRAR <u>MAY 4 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case within 72 hours after death.

VR A15 (4)  
20 M 1/66

Cleaned by Mr. Charles Judge

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
05378			
CERTIFICATE OF DEATH			
05376			
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 1b <i>D.O.A.</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Adelphi</i>		d. STREET ADDRESS <i>9709 23rd Avenue</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sanitarium and Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Lenore B. Hungerford</i>		4. DATE OF DEATH Month <i>April</i> Day <i>11</i> Year <i>1967</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 17, 1901</i>
9. AGE (In years lost birthday) <i>75</i> yrs.		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Musician</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Music</i>	
11. BIRTHPLACE (County & State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Millard Brownlee</i>		14. MOTHER'S MAIDEN NAME <i>Frances Mc Caleb</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>089-18-9533-A</i>	
17. INFORMANT <i>Charles G. Hungerford</i>		Address <i>9704 23rd Avenue Adelphi, Maryland</i>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>(Probable) Acute Myocardial Infarction</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c) <i>Hypertension, Obesity, Arteriosclerosis generalized</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hypertension, Obesity, Arteriosclerosis generalized</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. IDENTIFY UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <i>Hypertension, Obesity, Arteriosclerosis generalized</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan. 7, 1966</i> to <i>present</i> , 19 <i>1967</i> , that (I) (we) last saw the deceased alive on <i>13 March 1967</i> , and that death occurred at <i>8:05 PM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Fredrick J. Barr</i>		22b. DATE SIGNED <i>4-12-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Fredrick J. Barr</i>		22d. ADDRESS <i>4500 College Ave., College Park, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Interment</i>		23b. DATE THEREOF <i>Apr 15, 1967</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Forest Hill Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Utica, New York</i>	
24. FUNERAL DIRECTOR <i>Warner E. Humphrey, Inc.</i>		25a. REC'D BY REGISTRAR <i>APR 13 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. ADDRESS <i>8434 Georgia Avenue Silver Spring, Md.</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div> <div>1</div> <div> <div>05377</div> <div>05377</div> </div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> </div>																													
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u> c. LENGTH OF STAY IN 1b <u>2 Months 8 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Fairland Nursing Home</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C. - Washington</u> b. COUNTY <u>Wash. D.C.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wash. D.C.</u> d. STREET ADDRESS <u>4315 10th St. N.E. Wash. D.C.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
3. NAME OF DECEASED (Type or print) First <u>Catherine</u> Middle <u>Teresa</u> Last <u>Hurley</u>			4. DATE OF DEATH Month <u>April</u> Day <u>5</u> Year <u>1967</u>			5. SEX <u>Female</u>			6. COLOR OR RACE <u>white</u>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>August 15, 1892</u>			9. AGE (in years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>File Clerk - Retired</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>						11. BIRTHPLACE (County & State, or foreign country) <u>Brooklyn N.Y.</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>											
13. FATHER'S NAME <u>Father's John J. Hurley</u>						14. MOTHER'S MAIDEN NAME <u>Aguilla M. Webb</u>						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO. <u>060-01-3362A</u>						17. INFORMANT <u>John J. Hurley - See Item #2</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> DUE TO (b) <u>Diabetes Mellitus</u> DUE TO (c)																		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)																		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>						20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>1-16</u> , 1961, to <u>4-5</u> , 1967, that (I) (we) last saw the deceased alive on <u>4-4</u> , 1967, and that death occurred at <u>3A</u> M, from the causes and on the date stated above.																		22b. DATE SIGNED <u>4-5-67</u>											
22a. SIGNATURE <u>R.C. Kirchner</u>																		22c. PHYSICIAN'S NAME (Type) <u>R.C. KIRCHNER</u>		22d. ADDRESS <u>Takoma Park, 6480 New Hampshire Ave. N.D.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>						23b. DATE THEREOF <u>4-7-1967</u>						23c. NAME OF CEMETERY OR CREMATORY <u>St. Charles Cemetery Long Island N.Y.</u>						23d. LOCATION (City, town or county) (State)											
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> ADDRESS <u>5130 Wisc. Ave. N.W. Wash. DC.</u>																		25a. REC'D BY REGISTRAR <u>APR 10 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>									





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. The 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #11,13 & 14 Inform taken from birth cert

05380

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05373

1 PLACE OF DEATH a CITY <b>Montgomery</b> b COUNTY <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Montgomery</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c LENGTH OF STAY IN 1b <b>5 mins.</b>	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>White Oak</b>
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		d STREET ADDRESS <b>11301 Stewart Lane</b>	e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) <b>Baby Girl Hyson</b>		4 DATE OF DEATH Month <b>10</b> , April, <b>67</b> Day <b>19</b> Year <b>19</b>	
f SEX <b>Female</b>	6 COLOR OR RACE <b>Negro</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>10, Apr, 67</b>
9a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	9. AGE (In years or birth day) yrs <b>0</b>
11 BIRTHPLACE (State or foreign country) <b>White Oak, Mont. Co.</b>		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME <b>Bill Smith</b>		14. MOTHER'S MAIDEN NAME <b>Dorothy Wilkinson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.	
17 INFORMANT <b>Hospital Records</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per item for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory Failure due to Prematurity</b> DUE TO (b) <b>to Prematurity</b> DUE TO (c) <b>to Prematurity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Belden R. Reap</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BELDEN R. REAP M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <b>April 11, 1967</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>4/12/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Silver Spring Ind.</b>	23d. LOCATION (City or town) (County) (State)
24 FUNERAL DIRECTOR <b>Hyson Wheeler - Rockville, Ind.</b>		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>
DATE <b>APR 13 1967</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05381

CERTIFICATE OF DEATH

05379

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home 901 Arcola Avenue		d. STREET ADDRESS 2400 19th St., N.W. Apt. 104		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Andrew Irwin		First Middle Last		4. DATE OF DEATH Month Day Year APRIL 22 19 67	
5. SEX male	6. COLOR OR RACE Caus.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1884		9. AGE (In years lost birthday) 82 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) teacher of theology		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Markdale, Ontario, Canada	
13. FATHER'S NAME Henry D. Irwin		14. MOTHER'S MAIDEN NAME Mary Anne Cunningham		12. CITIZEN OF WHAT COUNTRY? Canada	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 458-50-7028-A		17. INFORMANT Nursing Home Records -	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1200 DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Arteriosclerotic Ht. disease, 3 mos. (c)		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Ca of the prostate suspected.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Oct. 1966, to April-22 1967, that (I) (we) last saw the deceased alive on Apr. 22, 1967, and that death occurred at 1:00 A.M. from causes and on the date stated above.			
22a. SIGNATURE S. J. Randall		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED APR. 22 1967	
22c. PHYSICIAN'S NAME (Type) S. J. RANDALL, M.D.		22d. ADDRESS 3001 VEAZEY TERR. N.W. DC			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-22-67		23c. NAME OF CEMETERY OR CREMATORY Georgetown Univ. Med. School	
23d. LOCATION (City or Town) (County) (State) Washington, D.C.		23e. REC'D BY REGISTRAR James E. DeVol		23f. REGISTRAR'S SIGNATURE James E. DeVol	
23g. DATE MAY 1 1967		23h. REGISTRAR'S SIGNATURE James E. DeVol			



05382

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY in 1b <u>42 days</u>		d. STREET ADDRESS <u>2101 16th ST NW</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home</u>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NAUM</u> Middle <u>JASNY</u> Last <u>JASNY</u>		4. DATE OF DEATH Month <u>4</u> Day <u>22</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/25/1883</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ECONOMIST</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Michael JASNY</u>		14. MOTHER'S MAIDEN NAME <u>UroSA JASNY</u>	
15. WAS DECLARED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>546-44-2486A</u>	
17. INFORMANT <u>MRS. MILTON MOSS</u> Address <u>8504 WHITTIER BLVD. BETHESDA, MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>416X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Nephrosclerosis</u> DUE TO <u>Generalized arterio-sclerosis</u> (c) <u>CVA</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>29m</u> <u>15y</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>CVA</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>pm</u> <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <u>Merton L. White</u>		22b. DATE SIGNED <u>22 Apr 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>MERTON L. WHITE</u>		22d. ADDRESS <u>9911 George Ave Silver Spring Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	23b. DATE THEREOF <u>4/24/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CREM.</u>	23d. LOCATION (City or Town) (County) (State) <u>SUITLAND, MD.</u>
24. FUNERAL DIRECTOR <u>JOS. GAWLER'S SONS, 3130 W. AVE. NW, WASH. DC</u>		25a. REC'D BY REGISTRAR <u>APR 26 1967</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

W.L. White h.d. covering for R. Bancroft h.d. Terminal illness feel documents. 1 and 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



05383

05381

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

053884

## CERTIFICATE OF DEATH

053882

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Fairfax</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>19 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Md. 20014</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Carl Emerson Johnson</b>		4. DATE OF DEATH Month Day Year <b>April 11 19 67</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>20 November 1920</b>
9 AGE (In years last birthday) <b>46 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accountant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Louis Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Alberta Coles</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes 1942-45, 1952-54</b>		16. SOCIAL SECURITY NO. <b>098-12-2493</b>	
17. INFORMANT <b>The Medical Records</b>		18. ADDRESS <b>The Clinical Center, Bethesda, Maryland 20014</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Cardiorespiratory collapse</b> DUE TO (b) <b>Severe Glucose Deficiency</b> DUE TO (c) <b>Fibrosarcoma</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>7 hours</b> <b>12 hours</b> <b>2 years</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS ALTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>March 23, 19 67</b> , to <b>April 11, 19 67</b> , that <del>he</del> (we) last saw the deceased alive on <b>April 11, 19 67</b> , and that death occurred at <b>5:00 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <i>Joel Rubenstein</i>		22b. DATE SIGNED <b>12 March 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Joel Rubenstein, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</b>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/14/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Grace Hill</b>	23d. LOCATION (City or Town) (County) (State) <b>Birmingham, Ala.</b>
24. FUNERAL DIRECTOR <i>Greene Funeral Home</i>		25a. REC'D BY REGISTRAR <b>APR 14 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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05383

## CERTIFICATE OF DEATH

05383

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington GARDENS</u>		d. STREET ADDRESS <u>Oakwood Terrace</u>	
3. NAME OF DECEASED (Type or print) <u>CLARA E. Johnson</u>		4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 4 1869</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (County & State, or foreign country) <u>INDIANA</u>
13. FATHER'S NAME <u>George S. Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Clara Burbank</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	17. INFORMANT <u>Fred Beyer 129 12th St. S.E. D.C.</u>
18. CAUSE OF DEATH (Enter an y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gall bladder perforation.</u> DUE TO (b) <u>chronic (+ acute) cholecystitis</u> DUE TO (c) <u>1 yr.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12-7, 1966</u> to <u>4-7, 1967</u> , that (I) (we) last saw the deceased alive on <u>4-3, 1967</u> , and that death occurred at <u>1:00 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>D.S. Sengstack M.D.</u>		22b. DATE SIGNED <u>4-7-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>G.F. Sengstack</u>		22d. ADDRESS <u>9241 Columbia Blvd. Silver Spring Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	23b. DATE THEREOF <u>Apr. 8, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	23d. LOCATION (City or Town) (County) (State) <u>Surtland P.O. Md.</u>
24. FUNERAL DIRECTOR <u>Joseph Gawlor Sons</u>		25a. RECD BY REGISTRAR <u>APR 12 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



05386

## CERTIFICATE OF DEATH

05384

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>	
c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		d. STREET ADDRESS <b>7409 Aspen Avenue</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium &amp; Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED <b>LAWRENCE</b> First Middle Last <b>Rush Johnson</b>		4. DATE OF DEATH Month <b>April</b> Day <b>20</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 8, 1918</b>
9. AGE (In years last birthday) yrs <b>48</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Builder</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>H. RUSH Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Mabel Straw</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW2</b>		16. SOCIAL SECURITY NO. <b>212-14-1895</b>	
17. INFORMANT <b>Mrs. Tressa C. Johnson</b>		Address <b>same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute Myocardial Infarction</b> DUE TO (c) <b>Acute Coronary Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH. <b>30 Min</b> <b>30 Min</b> <b>30 Min</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Arteriosclerotic Cardiovascular Disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>Sept</b> , 19 <b>66</b> , to <b>April</b> , 19 <b>67</b> , that (1) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>1:35 a.m.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Wilford D. Meyers M.D.</b>		22b. DATE SIGNED <b>April 20, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wilford D. Meyers M.D.</b>		22d. ADDRESS <b>8323 Haddon Drive Takoma Park Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>April 22, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>George Washington</b>	23d. LOCATION (City or Town) (County) (State) <b>Adeleph, Prince Geo. Co. Md</b>
24. FUNERAL DIRECTOR <b>Charles Judge</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>
DATE <b>APR 24 1967</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, forwarding the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05387

05385

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY in 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SUBURBAN</u>		d. STREET ADDRESS <u>10518 Weymouth St</u>	
3 NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Kenneth</u> Last <u>Jones</u>		4 DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2-11-1909</u> 64 yrs
10a. USLA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Author</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>John Jones</u>		14 MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes Navy</u>		16. SOCIAL SECURITY NO <u>378-30-7669</u>	
17 INFORMANT <u>Wife</u> Address <u>Same as Item 2.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
DUE TO (b) <u>Cardio Vascular Disease</u>		years	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		22. DATE SIGNED <u>4/11/67</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-17-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Alexandria Natl Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Alexandria, Virginia</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>APR 13 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>	





FOR STATE HEALTH DEPT.

05388

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05386

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>	
c. LENGTH OF STAY IN 1b <u>4 hrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hosp of Sil. Spg.</u>		d. STREET ADDRESS <u>12102 Livingston St</u>	
3 NAME OF DECEASED (Type or print) <u>Gertrude Mae Katz</u>		4 DATE OF DEATH <u>April 20</u> 19 <u>67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-29-07</u>
		9. AGE (in years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Mins <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11 BIRTHPLACE (State or foreign country) <u>DC</u>
12 CITIZEN OF WHAT COUNTRY <u>USA</u>			
13 FATHER'S NAME <u>Robert Hadan</u>		14 MOTHER'S MAIDEN NAME <u>Gertrude Reed</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>015-14-4425</u>	
17. INFORMANT <u>Col. David G. Katz</u>		1210 <u>Livingston St</u> <u>Wheaton, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u> DUE TO (b) <u>Myocardial rupture and cardiac Tamponade</u> DUE TO (c) <u>Acute myocardial infarction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>1 hr.</u> <u>8-9 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. Rogers MD</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John S. Rogers MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Apr 25, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>APR 27 1967</u>	
ADDRESS <u>117 Georgia Ave SE Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05389

## CERTIFICATE OF DEATH

05387

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in no event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Rockville</u>		c. LENGTH OF STAY IN 1b <u>Rural - Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12316 McCrossin Lane</u>		d. STREET ADDRESS <u>12316 McCrossin Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Leslie Davis Keller</u>		4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>1967</u>	
5. SEX <u>hy</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 17, 1883</u>
9. AGE (in years less birthday) yrs <u>83</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret.</u>	
11. BIRTH PLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Mr. W. W. Moats - Thess #1</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>Atherosclerosis Coronary</u> DUE TO (c) <u>Arterio Sclerosis</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> <u>20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>65</u> , to <u>April</u> , 19 <u>67</u> , that (I) (we) lost the deceased alive on <u>30 March 1967</u> , and that death occurred on <u>April 6, 1967</u> at <u>1:34 A.M.</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>S. Murphy</u>		22b. DATE SIGNED <u>April 6, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wm S. Murphy</u>		22d. ADDRESS <u>Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/9/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Regesters Chapel</u>	23d. LOCATION (City or town) (County) (State) <u>Stafford Co. Va</u>
24. FUNERAL DIRECTOR <u>Spordt-Wheeler</u>		25a. REC'D BY REGISTRAR DATE <u>APR 7 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>John C. Jones</u>		25c. ADDRESS <u>1331 Rockville Pike Rockville, Md.</u>	



## CERTIFICATE OF DEATH

05380

05388

1 PLACE OF DEATH a COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>	
b CITY OR TOWN (If outside corporate limits, write R.R.A. and give nearest town) <u>Silver Spring</u>		c LENGTH OF STAY IN 1b <u>6 hrs 45 min</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital of Silver Spring</u>		e STREET ADDRESS <u>228 Thistle Drive</u>	
3 NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>S</u> Last <u>Kempf</u>		4. DATE OF DEATH Month <u>4</u> Day <u>2</u> Year <u>19 67</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/19/61</u>
9 AGE (in years last birthday) <u>5</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13 FATHER'S NAME <u>Robert J. Kempf</u>		14 MOTHER'S MAIDEN NAME <u>Nancy Welmeyer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Robert J. Kempf</u>		Address <u>228 Thistle Drive Silver Spring, Maryland</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Acute yellow atrophy of liver</u> DUE TO (c) <u>Viral hepatitis</u>			19 INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6-16</u> , 19 <u>64</u> , to <u>April 2</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>April 2</u> , 19 <u>67</u> , and that death occurred at <u>2:45 PM</u> , from causes and on the date stated above.			
22a SIGNATURE <u>Carolyn S. Pincock</u> M.D.		22b. DATE SIGNED <u>4/3/67</u>	
22c PHYSICIAN'S NAME (Type) <u>Carolyn Pincock, M.D.</u>		22d ADDRESS <u>1944 Seminary Rd., Silver Spring, Md.</u>	
23a BURIAL, CREMATION, REINSTATEMENT <u>Burial</u>	23b DATE THEREOF <u>Apr 6, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>
24 FUNERAL DIRECTOR <u>John E. Thomas</u> ADDRESS <u>434 Georgia Avenue</u>		25a REC'D BY REGISTRAR <u>APR 7 1967</u>	
<u>Barner E. Humphrey, Inc. Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION  
 Cleared with Medical Examiner 4/2/67 MLC

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VA A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05391

CERTIFICATE OF DEATH

05389

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. LENGTH OF STAY IN 1b <b>6 weeks</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Potomac Valley Nursing Home</b>		d. STREET ADDRESS <b>5016 Wyandot Court</b>	
3. NAME OF DECEASED (Type or print) <b>Evelyn S Kennedy</b>		4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 22 '81</b>
9. AGE (In years last birthday) <b>85 yrs.</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>17</b> Hours <b>17</b> Min <b>17</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Columbus, Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ferdinand George Frank</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jaeger</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>- - -</b>		16. SOCIAL SECURITY NO. <b>- - -</b>	
17. INFORMANT <b>Mrs. Carlotta E. Johnston</b>		Address <b>- - -</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Anoxia</b> DUE TO <b>354X</b> (b) <b>Diffuse Cerebral Atherosclerosis</b> DUE TO <b>Generalized Atherosclerosis</b> (c) <b>undetermined</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>none</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 25, 1965</b> , to <b>17 April, 1967</b> , that (I) (we) last saw the deceased alive on <b>17 April 1967</b> , and that death occurred at <b>5:45 P.M.</b> from causes and on the date stated above			
22a. SIGNATURE <b>Stanley M. Bialek</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Stanley M. BIALEK</b>		22d. ADDRESS <b>8218 Wisconsin Ave. Beth Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4-20-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>
24. FUNERAL DIRECTOR <b>Joseph Gawlers</b>		25. REGD BY REGISTRAR <b>APR 21 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





**FOR STATE HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN ID <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>West San &amp; Hosp. Center</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>7312 15th Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas Enos Kingston</u>			4. DATE OF DEATH Month Day Year <u>April 23 1967</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-18-09</u>	9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Corp Law</u>		11. BIRTHPLACE (State or foreign country) <u>Georgia</u>			
13. FATHER'S NAME <u>Wm. Kingston</u>			14. MOTHER'S MAIDEN NAME <u>Hulda Louise Glibreath</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT <u>Dorothea Kingston</u> Address <u>7312 15th Avenue Takoma Park, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar pneumonia</u> 447X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John S. Ray</u> M.D. EXAMINER'S NAME (Type) <u>John S. Ray</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>4-23-67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>Apr 24, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>	23d. LOCATION (City, town or county) (State) <u>Prince Georges Co., Md.</u>				
24. FUNERAL DIRECTOR <u>Glen Carter</u> 8434 Georgia Avenue <u>Warner E. Humphrey, Inc.</u> Silver Spring, Md.		25a. REC'D BY REG. STRAR <u>APR 27 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				



FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05393

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05391

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Virginia		b. COUNTY Arlington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bealls Island		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac River				d. STREET ADDRESS 1705 S. Quincey Street	
3. NAME OF DECEASED (Type or print) First ROY Middle A. Last KINNEY		4. DATE OF DEATH Month April 1, Day 167		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1940	9. AGE (in years last birthday) 26 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Installing Furnaces		11. BIRTHPLACE (State or foreign country) XXXXXX Maryland	
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME Harold Kinney		14. MOTHER'S MAIDEN NAME Priscilla Coleman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-38-1711		17. INFORMANT Margaret E. Kinney-Item # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> 800X DUE TO <u>Drowning</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (b) (c)					INTERVAL BETWEEN ONSET AND DEATH 3 MIN.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Boat - Swam Ped and was thrown in river and drowned.			
20c. TIME OF INJURY Month, Day, Year Hour am. 4:30 p.m. 4/1 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) River	
20f. (City or town) Bealls Island Md.		20g. (County) Md.		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John G. Boll		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 4/14/67	
EXAMINER'S NAME (Type) John G. Boll		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Frostburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-16-67		23c. NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery	
23d. LOCATION (City, town or county) Frostburg, Md.		23e. REC'D BY REGISTRAR APR 18 1967		23f. REGISTRAR'S SIGNATURE Charles Judge	
24. FUNERAL DIRECTOR Joseph R. Durst, Sr., Frostburg, Md.					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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05394

## CERTIFICATE OF DEATH

05392

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN lb <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		d. STREET ADDRESS <b>13906 Marianna Dr.</b>	
3 NAME OF DECEASED (Type or print) First <b>Rosita</b> Middle <b>Catherine</b> Last <b>Knott</b>		4. DATE OF DEATH Month <b>April</b> Day <b>2</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/22/39</b>
9. AGE (In years last birthday) <b>28 yrs</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <b>Cabaldo, Italy</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Emilio Yon</b>		14. MOTHER'S MAIDEN NAME <b>Armida Yanutolo Yon</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Husband,</b>		Address <b>Robt. E. Knott 13109 Marianna Dr. Rkvl., Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CONGESTIVE HEART FAILURE</b> (c) <b>CHRONIC UREMIA</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>3 MONTHS</b> <b>1 YEAR</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>① HYPERTENSION ② NEPHROCALCINOSIS</b>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>OCTOBER, 1966</b> to <b>MARCH 2, 1967</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>MARCH 2, 1967</b> , and that death occurred at <b>7:40 P.M.</b> from causes and on the date stated above.			
22a SIGNATURE <b>Dennis J. Hand MD</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>DENNIS J. HAND</b>		22d. ADDRESS <b>10427 MONTROSE AVE. BETHESDA, MD</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-6-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Silver Spring, Maryland</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a REC'D BY REGISTRAR <b>APR 7 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



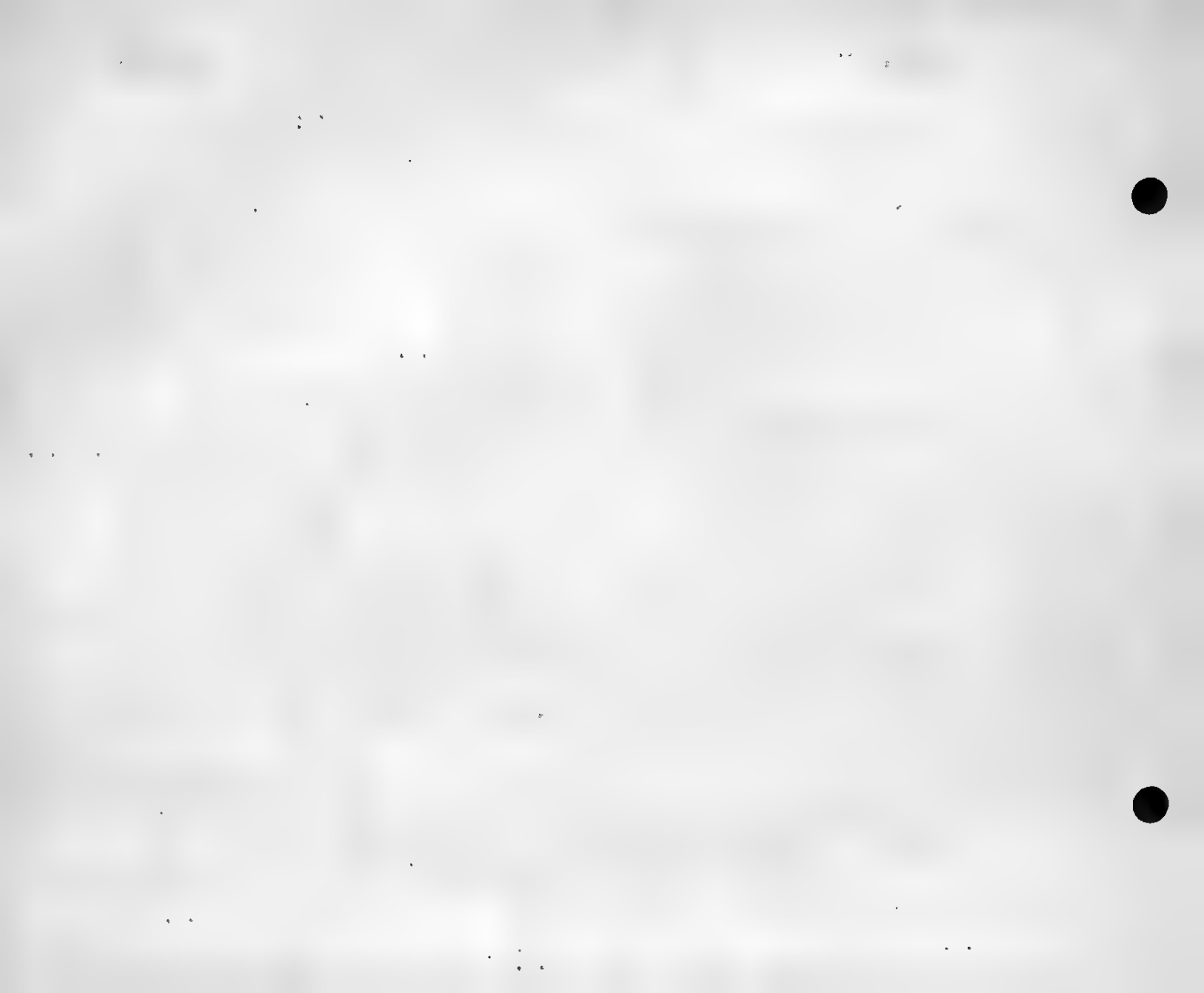
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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*Medical Examiner notified will approve*

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
05395					05393							
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)							
a. COUNTY <u>Montgomery</u> MARYLAND					a. STATE <u>M.C.</u> b. COUNTY <u>✓</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>							
c. LENGTH OF STAY IN 1b <u>14 hrs on Mon</u>					d. STREET ADDRESS <u>45 Nicholson St.</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>St. Elizabeth's Hospital</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH			
			<u>WILLIAM</u>				<u>KOHLER</u>		Month <u>APRIL</u> Day <u>4th</u> Year <u>1967</u>			
5. SEX <u>1</u>		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/11/1932</u>		9. AGE (In years last birthday) <u>35</u> yrs.		IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Public</u>		11. BIRTHPLACE (County & State, or foreign country) <u>M.C.</u>			12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Unk</u>					14. MOTHER'S MAIDEN NAME <u>Augusta</u> <u>Unk</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Dr. Hillman</u>			Address <u>45 Nicholson St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> <u>CARDIAC ARRHYTHMIA</u>										<u>18 Hrs</u>		
DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>										<u>2 yrs</u>		
DUE TO (c) <u>ARTERIOSCLEROSIS</u>												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>DIABETES MELLITUS</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year			20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
Hour a.m. <u>19</u> p.m.			While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work									
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> , 19 <u>55</u> , to <u>4-4</u> , 19 <u>67</u> , that (I) <u>was</u> last saw the deceased alive on <u>4-3-</u> 19 <u>67</u> , and that death occurred at <u>5:05</u> A.M. from the causes and on the date stated above.												
22a. SIGNATURE <u>Samuel A. Hillman</u>										22b. DATE SIGNED <u>4-4-67</u>		
22c. PHYSICIAN'S NAME (Type) <u>SAMUEL A. HILLMAN, M.D.</u>					22d. ADDRESS <u>8829 Flower Avenue</u> <u>Silver Spring, Maryland 20901</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)				
<u>Burial</u>			<u>4/7/67</u>		<u>Two St. Hill Cemetery</u>			<u>Washington D.C.</u>				
24. FUNERAL DIRECTOR <u>W. J. Hunsicker &amp; Son Funeral Home</u>					ADDRESS <u>5732 Gepp Rd. in</u>		25a. REC'D BY REGISTRAR <u>APR 7 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05396

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05394

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived f institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PR. GEO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAXMATA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SAN-HOSP</u>		d. STREET ADDRESS <u>3921 Oglesborpe St</u>	
3. NAME OF DECEASED (Type or print) <u>ARTHUR CHRISTIAN KRITES</u>		4. DATE OF DEATH <u>APRIL 21</u> 19 <u>67</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-17-98</u>
9. AGE (In years last birthday) <u>69</u> yrs		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINE OPERATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>	
11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>EDWARD KRITES</u>		14. MOTHER'S MAIDEN NAME <u>MARY WICKESSER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>297031104</u>	
17. INFORMANT <u>MARY G. KRITES</u> Address <u>SAME AS #2.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>4201 Acute myocardial infarction</u> DUE TO (b) <u>Chronic myocardial infarction</u> DUE TO (c) <u>last.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John W. Rogers MD</u>		22. DATE SIGNED <u>4/21/67</u>	
EXAMINER'S NAME (Type) <u>John W. Rogers MD</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>APRIL 25, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN</u>	23d. LOCATION (City or Town) (County) (State) <u>BLADENSBURG, MARYLAND</u>
24. FUNERAL DIRECTOR <u>W. W. CHAMBERS Co. RIVERDALE, MD</u>		25a. REC'D BY REGISTRAR <u>APR 25 1967</u>	25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# CERTIFICATE OF DEATH

05397

05395

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Rhode Island</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN TB <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cranston</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban (FERDINAND)</u>				d. STREET ADDRESS <u>97 Capers St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Salvador</u> Last <u>Kullberg</u>				4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>1967</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 8 - 1898</u>	
9. AGE (In years last birthday) yrs. <u>69</u>		10. F. UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min.		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if ret red) <u>Machinist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>US Gov't</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Providence - Rhode Island</u>	
13. FATHER'S NAME <u>Fredrick Kullberg</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Peterson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>1918</u>				16. SOCIAL SECURITY NO <u>037-03-7526 A</u>		17. INFORMANT <u>Mr Charles W. Leake - 8715 Montgomery Ave (daughter)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SEPTICEMIA</u> DUE TO (b) <u>PERITONITIS, LOCALIZED</u> DUE TO (c) <u>ACUTE CHOLECYSTITIS WITH FOCAL RUPTURE</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3-4 DAYS</u> <u>3-4 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Aplastic Anemia</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/30</u> , 19 <u>67</u> , to <u>present</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/7</u> , 19 <u>67</u> , and that death occurred at <u>2:30 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>John B. Umhan</u>				22b. DATE SIGNED <u>4/8/67</u>		22c. PHYSICIAN'S NAME (Type) <u>John B. Umhan</u>	
22d. ADDRESS <u>8805 Conn. Ave. Ch Ch. Md</u>		22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>APR. 11, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Anns Church Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Cranston Rhode Island</u>	
24. FUNERAL DIRECTOR <u>James E. De Vol 2222 W 22 Ave NW DC</u>				25a. REC'D BY REGISTRAR <u>APR 12 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05398

05396

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c LENGTH OF STAY IN TB <b>18 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>		e STREET ADDRESS <b>OLNEY</b>	
3 NAME OF DECEASED (Type or print) First <b>JACK</b> Middle <b>ARTHUR</b> Last <b>LADSON</b>		4 DATE OF DEATH Month <b>APRIL</b> Day <b>5</b> Year <b>1967</b>	
5 SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/19/08</b>
9. AGE (In years lost birthday) <b>58 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>VETERINARIAN</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>THOMAS A. LADSON</b>		14. MOTHER'S MAIDEN NAME <b>JESSIE DAVIS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215 36 4096</b>	
17. INFORMANT <b>MEDICAL RECORDS</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO <b>Biliary Obstruction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Carcinomatosis</b> DUE TO <b>Anaplastic Carcinoma of Lung</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 mo</b> <b>6 mo</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>4/8/67</b> to <b>4/15/67</b> , that (I) (we) last saw the deceased alive on <b>4/15/67</b> , and that death occurred at <b>2:45 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>C. H. LIGON, M.D.</b>		22b. DATE SIGNED <b>4/15/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>C. H. LIGON, M.D.</b>		22d. ADDRESS <b>SANDY SPRING MEDICAL CENTER, ROCKVILLE, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>April 8 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn</b>	23d. LOCATION (City or Town) (County) (State) <b>Rockville Montgomery Md.</b>
24. FUNERAL DIRECTOR <b>Francis H. Barber</b>		25a. REGISTRY CLERK <b>Laytonsville Md.</b>	
25b. REGISTRAR'S SIGNATURE <b>APR 10 1967</b>		25c. REGISTRAR'S SIGNATURE <b>Wm. Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05397

05397

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5608 Pollard Road,</b>		d. STREET ADDRESS <b>5608 Pollard Road,</b>	
3. NAME OF DECEASED (Type or print) <b>Frances M. Lane</b>		4. DATE OF DEATH Month <b>April</b> Day <b>20</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 27, 1915</b>
9. AGE (In years last birthday) yrs. <b>51</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John Pawling</b>		14. MOTHER'S MAIDEN NAME <b>Bessie Dawling</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Edward F. Lane, 5608 Pollard Rd.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Metastatic Carcinoma ovary</b> (c) <b>Carcinoma ovary</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>July 1965</b> to <b>April 20 1967</b> , that (I) (we) last saw the deceased alive on <b>April 20 1967</b> , and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above			
22a. SIGNATURE <b>J. E. Fitzgerald</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>J. E. Fitzgerald</b>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 24, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Wheaton, Maryland.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. Don, Rev. Vol</b>		25. ADDRESS <b>Washington, D.C. 2222 Wis. Ave. N.W.</b>	
25a. REC'D BY REGISTRAR <b>APR 28 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05460

05398

1. PLACE OF DEATH a. COUNTY <i>Montgomery - Wheaton</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>D.C.</i> b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>					
c. LENGTH OF STAY IN 1b <i>25 days</i>				d. STREET ADDRESS <i>4810 47th St, N.W.</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Randolph Hills Nursing Home</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <i>MARY ELIZABETH LANEHART</i>				4. DATE OF DEATH Month Day Year <i>April 5 1967</i>					
5. SEX <i>Fe</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>11/23/1895</i>			
9. AGE (In years last birthday) <i>70</i> yrs.		10. FUND 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) <i>D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>NATURAL</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sales clerk</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Dept. Store</i>					
13. FATHER'S NAME <i>John Garrett Prenddile</i>				14. MOTHER'S MAIDEN NAME <i>Mary Elizabeth Gettner</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <i>578 12 2144A</i>		17. INFORMANT <i>Nursing Home Records</i> Address <i>Admission and Discharge Record</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <i>157X</i> IMMEDIATE CAUSE (a) <i>Carcinoma of Pancreas</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized arteriosclerosis</i>								INTERVAL BETWEEN ONSET AND DEATH <i>2 wks</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Feb 11 1963</i> to <i>April 5, 1967</i> , that (I) (we) last saw the deceased alive on <i>April 5 1967</i> , and that death occurred at <i>6:00 PM</i> , from the causes and on the date stated above.									
22a. SIGNATURE <i>C. V. Ryland</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>4-8-67</i>			
22c. PHYSICIAN'S NAME (Type) <i>C. V. RYLAND</i>				22d. ADDRESS <i>C. V. RYLAND</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE THEREOF <i>April 12, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Arlington Nat'l Cem.</i>		23d. LOCATION (City, town or county) (State) <i>Arlington, Va.</i>			
24. FUNERAL DIRECTOR <i>St. Hines Co. 2901 14th N.W.</i>				25a. REC'D BY REGISTRAR DATE <i>APR 12 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05401

CERTIFICATE OF DEATH

05399

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before adm ssion) a STATE <b>Maryland</b> b COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>15.1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>		d STREET ADDRESS <b>11811 Brooke Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>Clara Lyman Latham</b>		4. DATE OF DEATH Month <b>11</b> Day <b>23</b> Year <b>19 67</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-28-79</b>
9. AGE (In years lost birthday) <b>87 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Unemployed</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Amos Richardson</b>		14. MOTHER'S MAIDEN NAME <b>Cornelius</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Address</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>446X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>ARTERIOULAR NEPHROSCLEROSIS</b> (c) <b>GENERALIZED ARTERIOSCLEROSIS</b>		*INTERVAL BETWEEN DEATH AND DEATH <b>YRS.</b> <b>YRS.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I (a) <b>PYODERMA GANGRENOUSUM. CHEST WALL - ARTHRITIS - STROKES</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>SEPT 23 AM 1967</b> to <b>23 April 1967</b> , that (we) just saw the deceased alive on <b>23 April 1967</b> , and that death occurred at <b>2:15 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Donald P. Davis</b>		22b. DATE SIGNED <b>23 April 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert C. Snowden</b>		22d. ADDRESS <b>Rockville, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/27/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Eulalia Cem. Pa</b>	23d. LOCATION (City or Town) (County) (State) <b>Couderport, Pa.</b>
24. FUNERAL DIRECTOR <b>Robert C. Snowden</b>		25a. REC'D BY REGISTRAR <b>APR 27 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Richard J. Jones</b>

MEDICAL CERTIFICATION

4000

11

25/11/1941  
The following is a list of the  
names of the persons who  
were present at the meeting  
held on the 11th of the  
month of November 1941.

The names of the persons  
who were present at the  
meeting held on the 11th  
of the month of November  
1941 are as follows:

05402

## CERTIFICATE OF DEATH

05400

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Norfolk</b>	
c. LENGTH OF STAY IN lb <b>11 days</b>		d. STREET ADDRESS <b>302 East 27th Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Md. 20014</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mildred Pearl Lathan</b>		4. DATE OF DEATH Month Day Year <b>April 10 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>26 June 1907</b>
9. AGE (In years lost birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min <b>10 19 67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Crosling</b>		14. MOTHER'S MAIDEN NAME <b>Martha (Unknown)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>The Medical Records, Clinical Center, National Institutes of Health, Bethesda, Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Tubular Necrosis</b> DUE TO (b) <b>Radiation Recurrent Cancer of the Cervix</b> DUE TO (c) <b>Hypertensive &amp; Arteriosclerotic Cardiovascular Disease</b>	
19. INTERVAL BETWEEN ONSET AND DEATH <b>2 Yrs.</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION—GIVEN IN PART I (a) <b>Diabetes</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that <del>(XX)</del> (this hospital) attended the deceased from <b>March 30</b> , 1967, to <b>April 10</b> , 1967, that <del>(XX)</del> (we) last saw the deceased alive on <b>April 10</b> , 1967, and that death occurred at <b>2:49 PM</b> , from causes and on the date stated above.	
22a. SIGNATURE <b>Frank C. Sparks, M.D.</b>		22b. DATE SIGNED <b>April 14, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Frank C. Sparks, M. D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>\$/11/57</b>		23b. NAME OF CEMETERY OR CREMATORY <b>Harmony Memorial</b>	
23c. LOCATION (City or Town) (County) (State) <b>Lanham, Maryland</b>		24. FUNERAL DIRECTOR <b>Frazier's Funeral Home, Inc. 389 R.I. Ave. NW</b>	
25a. REC'D BY REGISTRAR <b>APR 19 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



05403

## CERTIFICATE OF DEATH

05401

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>4 1/2 hrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>5101 Ridgefield Road</u>			
3. NAME OF DECEASED (Type or print) <u>FANNIE MABEL LAUT</u>				DATE OF DEATH <u>April 26 1967</u>			
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 9, 1894</u>	9. AGE (In years last birthday) <u>72</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Quincy - Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Vincent M. Drussler</u>				14. MOTHER'S MAIDEN NAME <u>Nellie Peterson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>yes - Navy - WWII</u>		16. SOCIAL SECURITY NO. <u>220-505575</u>		17. INFORMANT <u>John A. Laut - husband - 5101 Ridgefield Road Bethesda Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage Massive vt Cerebrum</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 1956</u> to <u>April 26 1967</u> , that (I) (we) last saw the deceased alive on <u>April 26 1967</u> , and that death occurred at <u>11:30 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Michael M. Healy</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>4/26/67</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-1-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>				25a. REC'D BY REGISTRAR <u>MAY 2 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
5130 Wisconsin Ave., N.W., Wash. DC.							





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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05404

CERTIFICATE OF DEATH

05402

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm.sion) a. STATE <b>Tennessee</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>27 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Morristown</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Md. 20014</b>		d. STREET ADDRESS <b>1500 Oak Street</b>	
3 NAME OF DECEASED (Type or print) First <b>Herman</b> Middle <b>William</b> Last <b>Lawson</b>		4. DATE OF DEATH Month <b>April</b> Day <b>29</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 13, 1928</b>
9. AGE (In years last birthday) yrs. <b>38</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Publishing Co.</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Tennessee</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>James R. Lawson</b>	
14. MOTHER'S MAIDEN NAME <b>Clara Smith</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>409-38-8724</b>		17. INFORMANT Address <b>The Medical Record The Clinical Center, Bethesda, Md. 20014</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple pulmonary emboli</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Sagittal sinus thrombosis</b> DUE TO (c) <b>Rheumatic heart disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>terminal</b> <b>28 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Thrombosis of periprosthetic and deep femoral veins, right - 2 weeks</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 'a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>the</del> (this hospital) attended the deceased from <b>April 2</b> , 19 <b>67</b> , to <b>April 29</b> , 19 <b>67</b> , that <del>the</del> (we) last saw the deceased alive on <b>April 29</b> , 19 <b>67</b> , and that death occurred at <b>9:05 M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Robert Zelis</b>		22b. DATE SIGNED <b>29 April 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert Zelis, MD</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>May 2, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Jarnagin Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Morristown, Tennessee</b>
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY</b>		25. REC'D BY REGISTRAR <b>BETHESDA, MARYLAND</b>	
25a. MAY 3 1967		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05405.

CERTIFICATE OF DEATH

05403

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN 1b <b>22 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		d. STREET ADDRESS <b>1006 Merrimac Drive</b>	
3. NAME OF DECEASED (Type or print) <b>Harry Creighton League Jr.</b>		4. DATE OF DEATH Month <b>April</b> Day <b>29</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 5, 1929</b>
9. AGE (in years last birthday) <b>38</b> yrs		10. IF UNDER 1 YEAR Months <b>29</b> Days <b>29</b> Hours <b>67</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. NAVY Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, D.C.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harry Creighton League Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Clarice Wood</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO <b>579 34 3338</b>	
17. INFORMANT <b>Mrs. Doris S. League</b>		18. ADDRESS <b>1006 Merrimac Dr. Sliver Springs, Md.</b>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lymphosarcoma</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Apr. 7</b> , 19 <b>67</b> , to <b>Apr. 29</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Apr. 29</b> , 19 <b>67</b> , and that death occurred at <b>600A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <i>H. Defries</i>		22b. DATE SIGNED <b>30 April 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>LCDR H. DEFRIES MC USN</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>May 3, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery Arlington, Va.</b>	
24. FUNERAL DIRECTOR <b>Takoma Funeral Home</b>		25a. REC'D BY REGISTRAR <b>MAY 2 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



05406

CERTIFICATE OF DEATH

05404

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN 1b <u>18 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home</u>		d. STREET ADDRESS <u>8401 16th Street</u>	
3 NAME OF DECEASED (Type or print) <u>John Edmund Leatham</u>		4 DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 27, 1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>	9. AGE (In years last birthday) <u>84</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Brooklyn, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard W. Leatham</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Finnegan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>Yes</u>	17. INFORMANT <u>Grae S. Leatham</u> Address <u>8401 16th Street Silver Spring, Md.</u>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Sepsis</u> DUE TO (b) <u>Pneumonia</u> DUE TO (c) <u>...</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/25</u> , 19 <u>67</u> to <u>4/18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/18</u> , 19 <u>67</u> , and that death occurred at <u>4:22</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Raymond T. Benack</u> M.D.		22b. DATE SIGNED <u>4/18/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>RAYMOND T. BENACK MD</u>		22d. ADDRESS <u>4115 Polie Dr. Wheaton Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>Apr 19, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>	23d. LOCATION (City or town) (County) (State) <u>Prince Georges Co., Md.</u>
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>8430 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 20 1967</u>	25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05405

FOR STATE  
HEALTH DEPT

05407

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <i>Maryland</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Maryland</i>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN TB <i>2 days</i>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Schurman Hospital</i>		d STREET ADDRESS <i>#1 Box 49 1/2</i>	
3 NAME OF DECEASED (Type or print) <i>Marietta (Mrs) Lee</i>		4. DATE OF DEATH Month <i>April</i> Day <i>28</i> Year <i>1967</i>	
5. SEX <i>Female</i>	6 COLOR OR RACE <i>Negro</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>2/21-04-63</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life and retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	9 AGE (in years last birthday) <i>33</i> yrs
11. BIRTHPLACE (State or foreign country) <i>Maryland - Parkville</i>		12 CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13 FATHER'S NAME <i>James Edward Hehren</i>		14 MOTHER'S MAIDEN NAME <i>Marietta Johnson</i>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes/No, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17 INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broncho Pneumonia</i> DUE TO (b) <i>Inter Cranial Hemorrhage</i> DUE TO (c) <i>Auto Accident</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>9 1/2 weeks</i> <i>9 weeks</i>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>in auto accident bumped head causing hemorrhage</i>	
20c TIME OF INJURY Month, Day, Year <i>1300 - 2/21 1967</i>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e PLACE OF INJURY (Home form factory street off ce bldg etc) <i>Street</i>	20f (City or town), (County) (State) <i>Seneca - Mont. - Md.</i>
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John B. Ball</i> M.D.		22. DATE SIGNED <i>4/28/67</i>	
EXAMINER'S NAME (Type) <i>John B. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street city, town or county)	
23a BURIAL, CREMATION REMOVAL, Specify <i>BURIAL</i>	23b DATE THEREOF <i>5/2/67</i>	23c NAME OF CEMETERY OR CREMATORY <i>Sugarland Cem.</i>	23d LOCATION (City or town), (County) (State) <i>Sugarland Montg Md.</i>
24 FUNERAL DIRECTOR <i>Robert L. Snowden</i>		25a REC'D BY REGISTRAR <i>Rockville, Md.</i>	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>

1940

9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 841. 842. 843. 844. 845. 8

9. Mr. ...

71 424-27

— 2021 —



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

|  |  |   |  |
|--|--|---|--|
| 05408  |  | 05406   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Mont.</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Suburban</u>   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u>  |  |
| c. LENGTH OF STAY IN 1b <u>24 hrs.</u>   |  | d. STREET ADDRESS <u>6512 - Rockledge St. N.W.</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>F.</u> Last <u>Lehmann</u>   |  | 4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>1967</u>  |  |
| SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <u>9/30/77</u>  |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INTERIOR DECORATOR</u>   |  | 9b. AGE (In years last birthday) <u>89</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INTERIOR DECORATOR</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>SAME</u>   |  |
| 11. BIRTHPLACE (County & State, or foreign country) <u>NEBRASKA</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |
| 13. FATHER'S NAME <u>AUGUSTA HENRY LEHMANN</u>   |  | 14. MOTHER'S MAIDEN NAME <u>AUGUSTA</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)  |  | 16. SOCIAL SECURITY NO. <u>5070140494</u>   |  |
| 17. INFORMANT <u>MRS. ETTA RIDGELY (SAME AS #3)</u>  |  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u><br>DUE TO <u>arteriosclerotic Heart disease.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) |  | INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u><br><u>5 yrs.</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.   | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)  | 20f. (City or town) (County) (State)                                     |
| 21. I certify that (i) (this hospital) attended the deceased from <u>1 Jan. 1967</u> to <u>21 April 1967</u> , that (i) (we) last saw the deceased alive on <u>20 April 1967</u> , and that death occurred at <u>3:15 PM</u> , from the causes and on the date stated above.   |  |   |  |
| 22a. SIGNATURE <u>A. H. Richwine</u> M.D.  |  | 22b. DATE SIGNED <u>21 April 1967</u>   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>A. H. RICHWINE, MD.</u>  |  | 22d. ADDRESS <u>3522 WESTERN AVE CHEVY CHASE, MD.</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>   | 23b. DATE THEREOF <u>Apr. 22, 1967</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>  | 23d. LOCATION (City, town or county) (State) <u>Pt. Div. Co Maryland</u> |
| 24. FUNERAL DIRECTOR <u>Arthur Walters, 254 Carroll BLVD NE</u>  |  | 25. REC'D BY REGISTRAR <u>Charles Judge</u>   |  |
| 25b. REGISTRAR'S SIGNATURE   |  | DATE <u>APR 24 1967</u>   |  |

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FAX: 773-936-5001  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05409

CERTIFICATE OF DEATH

05407

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                                  | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Chevy Chase</u>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Chevy Chase</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>2945 TERRACE DRIVE</u>  |                                  | d. STREET ADDRESS<br><u>2945 TERRACE DRIVE</u>  |   |
| 3. NAME OF DECEASED (Type or print)<br><u>FANNIE PALACE LEVINSON</u>   |                                  | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>22</u> Year <u>1967</u>   |   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>April 15, 1909</u> |
| 9. AGE (In years lost birthday)<br><u>58</u> yrs   |                                  | 10. IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Min. <u>  </u>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>—</u>   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>RUSSIA</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>AMERICA</u>  |   |
| 13. FATHER'S NAME<br><u>ARON PALACE</u>  |                                  | 14. MOTHER'S MAIDEN NAME<br><u>TILLEY ROCKLIN</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>NO</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>578-64-6484</u>   |   |
| 17. INFORMANT<br><u>IRVIN LEVINSON - 2945 TERRACE DR</u>   |                                  | Address <u>CHEVY CHASE, MD</u>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u><br><u>3561</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Amyotrophic Lateral Sclerosis</u><br>DUE TO (c) <u>  </u> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>12 HOURS</u><br><u>2 years.</u>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Chronic Bronchitis</u>   |                                  |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>October</u> , 19 <u>66</u> , to <u>April 22, 1967</u> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <u>April 22</u> , 19 <u>67</u> , and that death occurred at <u>4:10 p.m.</u> from causes and on the date stated above.                           |                                  |   |   |
| 22a. SIGNATURE<br><u>Jack Crowell MD</u>   |                                  | 22b. DATE SIGNED<br><u>April 22, 1967</u>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>JACK CROWELL MD</u>   |                                  | 22d. ADDRESS<br><u>2025 EYE ST. N.W. Washington DC</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 23b. DATE THEREOF<br><u>4/24/67</u>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Beth Israel Adath Israel</u>  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><u>Beth Israel</u>   |   |
| 24. FUNERAL DIRECTOR<br><u>Sylvan S. Lewis &amp; Son, Inc</u>  |                                  | 25a. REC'D BY REGISTRAR<br><u>APR 25 1967</u>   |   |
| ADDRESS<br><u>Garrison, Md</u>   |                                  | 25b. REGISTRAR'S SIGNATURE<br><u>J. Charles Judge</u>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



05410

## CERTIFICATE OF DEATH

05408

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Virginia</b> b. COUNTY <b>Norfolk</b>                  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>   |  | c. LENGTH OF STAY IN 1b<br><b>29 Days</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>The Clinical Center, Bethesda, Maryland</b>  |  | d. STREET ADDRESS<br><b>1852 Ogden Street</b>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Donnie</b> Middle <b>Mae</b> Last <b>Lewis</b>  |  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>5</b> Year <b>19 67</b>   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>Negro</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12 April 1909</b>                             |
| 9. AGE (In years lost birthday) yrs<br><b>57</b>  |  | 10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  |
| 10b. KIND OF BUSINESS OR INDUSTRY<br><b>--</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Georgia</b>   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 13. FATHER'S NAME<br><b>John W. Cannon</b>  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Mattie Belle Hardrick</b>  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  |
| 16. SOCIAL SECURITY NO<br><b>Not Available</b>  |  | 17. INFORMANT<br><b>The Medical Records</b>   |  |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Intraperitoneal hemorrhage</b><br>DUE TO<br>(b) <b>Peritonitis</b><br>DUE TO<br>(c) <b>Radiation recurrent carcinoma of cervix</b>  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>36 hours</b><br><b>48 hours</b><br><b>1 year</b>   |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)   | 20f. (City or town) (County) (State)                                 |
| 21. I certify that <b>xx</b> (this hospital) attended the deceased from <b>7 March</b> , 19 <b>67</b> , to <b>5 April</b> , 19 <b>67</b> , that <b>xx</b> (we) last saw the deceased alive on <b>5 April</b> , 19 <b>67</b> , and that death occurred on <b>11:00M</b> , from causes on and on the date stated above. |  |   |  |
| 22a. SIGNATURE<br><b>Frank C. Sparks, M.D.</b>  |  | 22b. DATE SIGNED<br><b>6 April 1967</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Frank C. Sparks, M.D.</b>  |  | 22d. ADDRESS<br><b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   | 23b. DATE THEREOF<br><b>4/8/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION (City or Town) (County) (State)<br><b>Norfolk, Va.</b> |
| 24. FUNERAL DIRECTOR<br><b>Frazier's Funeral Home, Inc.</b>   |  | 25a. REC'D BY REGISTRAR<br><b>APR 11 1967</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  | 25c. REGISTRAR'S NAME<br><b>Charles Judge</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

05411

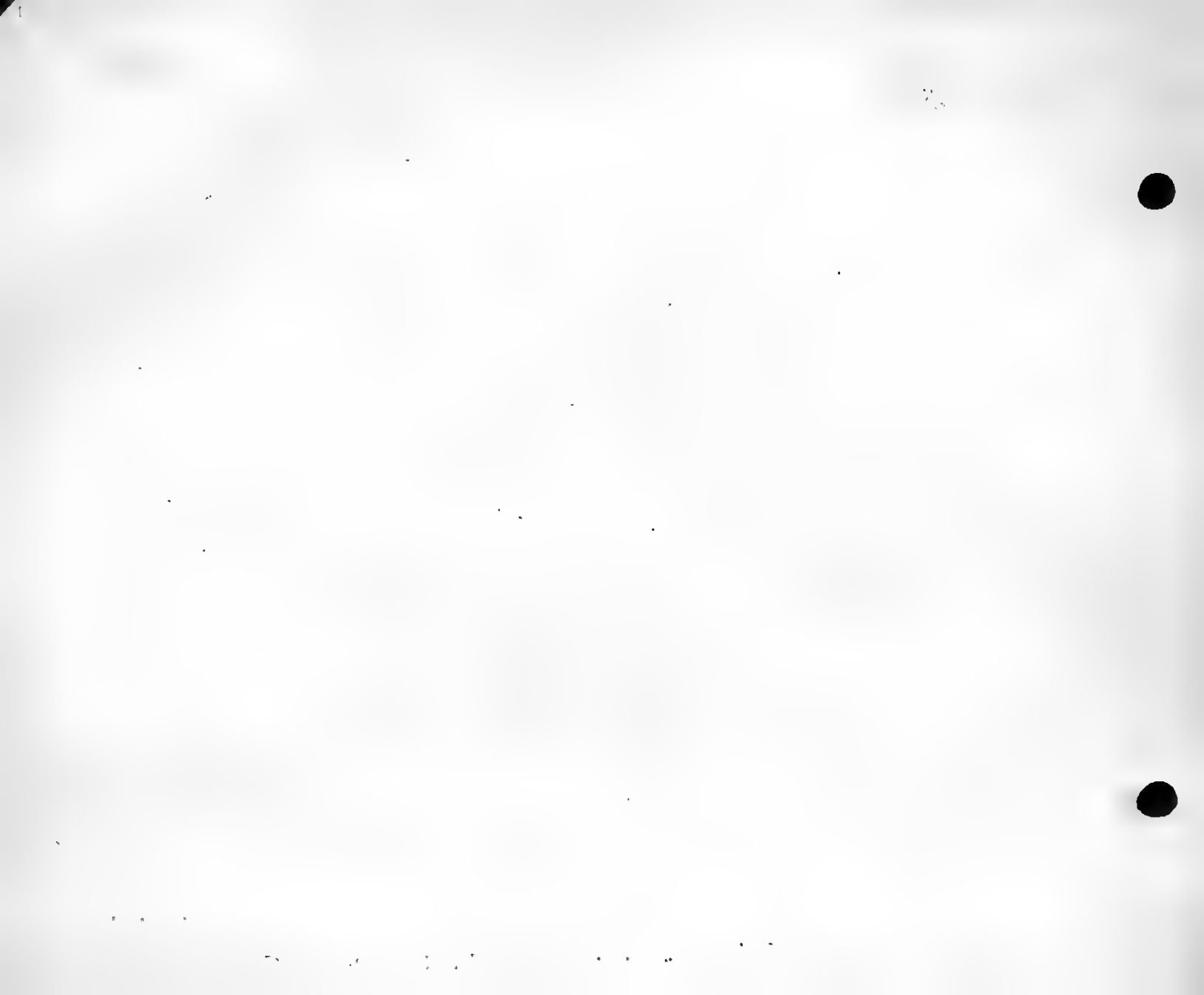
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05409

|  |   |  |                                      |
|--|---|--|--------------------------------------|
| 1 PLACE OF DEATH<br><i>Montgomery</i> MARYLAND   |   | 2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)<br><i>District of Columbia</i>  |                                      |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Kensington</i>   |   | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Washington</i>   |                                      |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><i>Kensington Nursing Home</i>  |   | d STREET ADDRESS<br><i>1510 VARNUM ST. N.W.</i>  |                                      |
| 3 NAME OF DECEASED (Type or print)<br><i>MAMIE B. LITTLE</i>   |   | 4 DATE OF DEATH<br><i>April 5 1967</i>   |                                      |
| 5 SEX<br><i>Fe</i>   | 6 COLOR OR RACE<br><i>Cauc</i>  | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><i>10-20-1869</i> |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Homemaker</i>   |   | 10b KIND OF BUSINESS OR INDUSTRY   | 9 AGE (In years)<br><i>97</i>        |
| 11 BIRTHPLACE (State or foreign country)<br><i>Georgia</i>   |   | 12 CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |                                      |
| 13 FATHER'S NAME<br><i>John L. Burkhalter</i>  |   | 14 MOTHER'S MAIDEN NAME<br><i>Virginia Burkhalter</i>  |                                      |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |   | 16 SOCIAL SECURITY NO.   |                                      |
| 17 INFORMANT<br><i>Home Records</i>  |   | Address  |                                      |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br><i>Acute Myocardial Insufficiency</i><br><i>4401</i> DUE TO<br><i>Arteriosclerotic Heart Disease</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO<br>(c)  |   |  |                                      |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NA. DISEASE CONDITION GIVEN IN PART I(a)  |   |  |                                      |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |   | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |                                      |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m.<br>p.m.<br><i>19</i>  | 20d INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f (City or town) (County) (State)  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |   |  |                                      |
| ACTUAL SIGNATURE<br><i>Belden R. Reap</i> M.D.   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |                                      |
| EXAMINER'S NAME (Type)<br><i>BELDEN R. REAP M.D.</i>   |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |                                      |
| 23a BURIAL, CREMATION, REMOVAL (Specify)<br><i>burial</i>  |   | 23b DATE THEREOF<br><i>4/8/67</i>  |                                      |
| 23c NAME OF CEMETERY OR CREMATORY<br><i>Rock Creek Cemetery</i>  |   | 23d LOCATION (City or town) (County) (State)<br><i>Washington, D.C.</i>  |                                      |
| 24 FUNERAL DIRECTOR<br><i>The S.H. Hines Company</i><br><i>2901 14th St. N.W. Washington, D.C.</i>   |   | 25a REC'D BY REGISTRAR<br><i>APR 10 1967</i>   |                                      |
| 25b REGISTRAR'S SIGNATURE<br><i>Charles J. Jones</i>   |   | 22. DATE SIGNED<br><i>APRIL 5 1967</i>   |                                      |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 12 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

CLEARED WITH MEDICAL EXAMINER

|   |  |  |   |   |  |  |  |   |   |  |  |
|---|--|--|---|---|--|--|--|---|---|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |   |   |  |  |  |   |   |  |  |
| 05410<br>05412 Item#8Film#G3874/1-3/67  |  |  |   |   |  |  |  |   |   |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br>MONTGOMERY<br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>TAKOMA PARK<br>c. LENGTH OF STAY IN 1b<br>MINUTES<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br>WASHINGTON SAN. & HOSP.  |  |  |   |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br>MARYLAND<br>b. COUNTY<br>SILVER SPRING<br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>8023 PINEY BRANCH RD.<br>d. STREET ADDRESS<br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |   |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>SERECK ELLWOOD LIVEZEY  |  |  | 4. DATE OF DEATH<br>Month<br>4<br>Day<br>16<br>Year<br>1967 |   |  | 5. SEX<br>MALE   |  |   | 6. COLOR OR RACE<br>WHITE   |  |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  | 8. DATE OF BIRTH<br>12-18-1905                              |   |  | 9. AGE (In years last birthday)<br>61 yrs.   |  |   | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.                    |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>PLUMBER CONT   |  |  |   |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>PLUMBING  |  |   | 11. BIRTHPLACE (County & State, or foreign country)<br>HARTFORD Co., Maryland |  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br>U.S.  |  |  |   |   |  | 13. FATHER'S NAME<br>JACOB LIVEZEY   |  |   |   |  |  |
| 14. MOTHER'S MAIDEN NAME<br>ROBERTS   |  |  |   |   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br>No   |  |   |   |  |  |
| 16. SOCIAL SECURITY NO.   |  |  |   |   |  | 17. INFORMANT<br>Mrs. Nora A. Livezey<br>Address   |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART Disease<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DIABETES MELLITUS<br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH<br>uncertain<br>15 years |  |  |   |   |  |  |  |   |   |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |   |   |  |  |  |   |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |  |  |   |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19   |  |  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                |   |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from JANUARY, 1964, to 4/6, 1967, that (I) (we) last saw the deceased alive on 4/6, 1967, and that death occurred at 3 P.M. from the causes and on the date stated above.  |  |  |   |   |  |  |  |   |   |  |  |
| 22a. SIGNATURE<br>Richard H. Pollen   |  |  |   | 22b. DATE SIGNED<br>4/6/67  |  |  |  | 22c. PHYSICIAN'S NAME (Type)<br>RICHARD H. POLLEN                   |   |  |  |
| 22d. ADDRESS<br>10400 CONN. AVE KENS, MD  |  |  |   | 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  |  |  |   |   |  |  |
| 23b. DATE THEREOF<br>Apr 10, 1967   |  |  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mount Zion Cemetery   |  |  |  | 23d. LOCATION (City, town or county) (State)<br>Sountain Green, Md. |   |  |  |
| 24. FUNERAL DIRECTOR<br>Takoma Park Funeral   |  |  |   | ADDRESS<br>254 Carroll Rd NW, DC.   |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE APR 10 1967                         |   |  |  |
| 25b. REGISTRAR'S SIGNATURE<br>Charles Vaughn  |  |  |   |   |  |  |  |   |   |  |  |



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05411

FOR STATE  
HEALTH DEPT.

054113

|   |                               |   |   |   |   |
|---|-------------------------------|---|---|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                               |   | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Cherry Chase</u>   |                               | c. LENGTH OF STAY IN 1b<br><u>3 wks</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Cherry Chase</u> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>3535 Cherry Chase Lake Dr.</u>   |                               |   | d. STREET ADDRESS<br><u>3535 Cherry Chase Lake Dr.</u>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3 NAME OF DECEASED (Type or print) <u>Katherine Davis Locke</u>   |                               |   | 4 DATE OF DEATH<br>Month <u>April</u> Day <u>9</u> Year <u>1967</u>   |   |   |
| 5. SEX<br><u>Fe.</u>  | 6. COLOR OR RACE<br><u>W.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>July 22, 1939</u>  | 9. AGE (In years lost birthday)<br><u>27</u> yrs.   | 10. UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Research Assistant</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Bethesda Naval Hospt. Penna.</u>  |   | 11. BIRTHPLACE (State or foreign country)<br><u>U.S.A.</u>  |   |
| 13. FATHER'S NAME<br><u>George David Davis</u>  |                               |   | 14. MOTHER'S MAIDEN NAME<br><u>Elizabeth Maynard</u>  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u> <u>None</u>   |                               | 16. SOCIAL SECURITY NO<br><u>153-28-2106</u>  |   | 17. INFORMANT<br><u>Edwin A. Locke</u> Address <u>11200 Lockwood Drive Silver Spring, Md.</u>           |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gun Shot Wound of Head</u><br>DUE TO (b) <u>Self-inflicted</u><br>DUE TO (c) <u>  </u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |                               |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>Seconds</u>  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                               |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                               | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)<br><u>Shot self in head with 32 cal. Pistol</u>                  |   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>4/9</u> 1967  |                               | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input checked="" type="checkbox"/><br>at work at work                                     |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>Home</u>                   |   |
|   |                               | 20f. (City or town) (County) (State)<br><u>Cherry Chase Mont. Md.</u>   |   |   |   |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                               |   |   |   |   |
| ACTUAL SIGNATURE<br><u>John G. Ball</u>   |                               | EXAMINER'S NAME (Type)<br><u>John G. Ball</u>   |   | 22. DATE SIGNED<br><u>4/11/67</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Cremation</u>   |                               | 23b. DATE THEREOF<br><u>Apr 12, 1967</u>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>St. Lincoln Crematory</u>                                      |   |
|   |                               | 23d. LOCATION (City or Town) (County) (State)<br><u>Prince Georges Co. Md.</u>  |   |   |   |
| 24. FUNERAL DIRECTOR<br><u>Glen Carter</u>  |                               | 25a. REC'D BY REGISTRAR<br><u>APR 17 1967</u>   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   |
| Address<br><u>8434 Georgia Avenue Silver Spring, Md.</u>  |                               |   |   |   |   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



05414

## CERTIFICATE OF DEATH

05412

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>SILVER SPRING</u>   |  | c. LENGTH OF STAY IN 1b<br><u>SILVER SPRING</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>QUEEN CHASE NURSING AND Convalescent Center</u>   |  | d. STREET ADDRESS<br><u>8600 16th ST.</u>   |   |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><u>PAULINE</u> <u>Lockett</u>  |  | 4. DATE OF DEATH<br>Month Day Year<br><u>APRIL</u> <u>10</u> <u>1967</u>  |   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>CAU</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>10 MARCH 1888</u>                                |
| 9. AGE (in years lost birthday)<br><u>79</u> yrs   |  | 10. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>WASHINGTON, D.C.</u>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>WASHINGTON, D.C.</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   |
| 13. FATHER'S NAME<br><u>JACK DREISONSTOCK</u>  |  | 14. MOTHER'S MAIDEN NAME<br><u>FANNY YOUNG</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>NO</u>  |  | 16. SOCIAL SECURITY NO.<br><u>NONE</u>  |   |
| 17. INFORMANT<br><u>MAXINE EIDEN</u>   |  | Address<br><u>8600 16th St. SILVER SPRING, MD</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Thrombosis of Cerebral Artery</u><br>DUE TO<br><u>332X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO<br>(c) |  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>19. WAS AUTOPSY PERFORMED?</u><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. <u>19</u>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                    |
| 21. I certify that <u>(1)</u> (this hospital) attended the deceased from <u>June 5, 1962</u> to <u>4-10, 1967</u> that (1) (we) last saw the deceased alive on <u>4-10-1967</u> , and that death occurred at <u>10:30 PM</u> , from causes and on the date stated above  |  |   |   |
| 22a. SIGNATURE<br><u>Max G. Sherer</u>   |  | 22b. DATE SIGNED<br><u>4-10-67</u>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>MAX G. SHERER MD</u>  |  | 22d. ADDRESS<br><u>800 Pershing Dr. Silver Spring Md</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   | 23b. DATE THEREOF<br><u>4-12-67</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>ADAS ISRAEL Cem</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>WASHINGTON D.C.</u> |
| 24. FUNERAL DIRECTOR<br><u>COLONIA FUNERAL HOME 4217 9th St. NW</u>  |  | 25a. REC'D BY REGISTRAR<br>DATE <u>APR 12 1967</u>  |   |
|  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05413

CERTIFICATE OF DEATH

05413

|   |  |   |  |   |  |  |   |
|---|--|---|--|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>   |  | c. LENGTH OF STAY IN TB<br><u>87 days</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Greenbelt</u>  |  | 14. 15. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>The Clinical Center, Bethesda, Maryland</u>  |  |   |  | d. STREET ADDRESS<br><u>57-R Ridge Road</u>   |  |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Keith</u> Middle <u>Andreas</u> Last <u>Longas</u>  |  |   |  | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>27</u> Year <u>1967</u>   |  |  |   |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>8 June 1960</u> |   | 9. AGE (In years lost birthday)<br><u>6</u> yrs. | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>   | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Student</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>None</u>  |  | 11. BIRTHPLACE (County & State or foreign country)<br><u>Washington, D.C.</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |   |
| 13. FATHER'S NAME<br><u>Socrates A. Longas</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Leona Blackman</u>   |  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |  | 16. SOCIAL SECURITY NO<br><u>None</u>   |  | 17. INFORMANT <u>The Medical Record</u><br><u>The Clinical Center, Bethesda, Maryland</u>   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Failure, Refractory</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>(b) <u>Suspected Drug Toxicity</u><br>DUE TO<br>(c) <u>Acute Lymphocytic Leukemia</u> |  |   |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 wks.</u><br><u>2 wks.</u><br><u>3 1/2 Yrs.</u>           |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |   |  |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |   |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |  |   |
| 21. I certify that (A) (this hospital) attended the deceased from <u>January 30, 1967</u> , to <u>April 27, 1967</u> , that (A) (we) last saw the deceased alive on <u>27 April 1967</u> , and that death occurred at <u>7:05 M.</u> from causes and on the date stated above.  |  |   |  |   |  |  |   |
| 22a. SIGNATURE<br><u>Herbert E. Kann, Jr.</u>   |  |   |  | 22b. DATE SIGNED<br><u>28 April 1967</u>  |  | 22c. PHYSICIAN'S NAME (Type)<br><u>Herbert E. Kann, Jr.</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>burial</u>  |  | 23b. DATE THEREOF<br><u>4/30/67</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Chesed Shel Emmes</u>  |  | 23d. LOCATION (City or town) (County) (State)<br><u>Hillside, Maryland</u>                             |   |
| 24. FUNERAL DIRECTOR<br><u>Bernard Danzansky &amp; Sons St., N.W. Wash. D.C.</u>  |  |   |  | 25a. REC'D BY REGISTRAR<br><u>GMAY 2 1967</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |   |





MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05416

CERTIFICATE OF DEATH

05414

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Dr. John Rogers (Medical Examiner) notified & certified by D.H. 4-19-67

|  |                              |  |                                      |
|--|------------------------------|--|--------------------------------------|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                              | 2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion)<br>a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>                    |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |                              | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |                                      |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>   |                              | d. STREET ADDRESS <u>9708 Montomab ave</u>   |                                      |
| 3 NAME OF DECEASED (Type or print) <u>JOHN ELDRIDGE LOVELESS</u>   |                              | 4. DATE OF DEATH <u>4</u> Month <u>19</u> Day <u>27</u> Year <u>67</u>   |                                      |
| 5 SEX <u>MALE</u>  | 6 COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF B RTH <u>Feb 11, 1895</u> |
| 9. AGE (In years last birthday) <u>72</u> yrs  |                              | 10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.  |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Interior Decorator</u>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>   |                                      |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>  |                              | 12. CITIZEN OF WHAT COUNTRY? <u>yes</u>  |                                      |
| 13. FATHER'S NAME <u>Harren R Loveless</u>   |                              | 14. MOTHER'S MAIDEN NAME <u>Carrie E Jones</u>   |                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>WW I</u>   |                              | 16. SOCIAL SECURITY NO. <u>578-03-4015</u>   |                                      |
| 17. INFORMANT <u>Wife</u> Address <u>Same as Item 2.</u>   |                              | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |                                      |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u><br>DUE TO (b) <u>Coronary Heart Disease</u><br>DUE TO (c) <u>?</u>  |                              | INTERVAL BETWEEN ONSET AND DEATH <u>acute</u>  |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                              |  |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |                              | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                              | 20f. (City or town) (County) (State)   |                                      |
| 21. I certify that (I) (this hospital) attended the deceased from <u>4-14</u> , 1967, to <u>4-19</u> , 1967, that (I) (we) last saw the deceased alive on <u>Dec 19</u> and that death occurred at <u>1:15 PM</u> , from causes and on the date stated above |                              |  |                                      |
| 22a. SIGNATURE <u>Marion Bankhead</u>  |                              | 22b. DATE SIGNED <u>4/19/67</u>  |                                      |
| 22c. PHYSICIAN'S NAME (Type) <u>J. Marion Bankhead</u>   |                              | 22d. ADDRESS <u>1505 Dole Dr. Silver Spring, Md.</u>   |                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                              | 23b. DATE THEREOF <u>4-21-67</u>   |                                      |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>  |                              | 23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>   |                                      |
| 24. FUNERAL DIRECTOR ADDRESS <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>   |                              | 25a. REC'D BY REGISTRAR <u>Charles Judge</u>   |                                      |
| 25b. REGISTRAR'S SIGNATURE   |                              | DATE <u>APR 24 1967</u>  |                                      |



05417

## CERTIFICATE OF DEATH

05415

|  |  |  |   |
|--|--|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>MARYLAND   |  | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Montgomery</b>                             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Kenwood</b>   |  | c. LENGTH OF STAY IN 1b<br><b>16 years</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Kenwood</b>                                 |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>5316 Oakland Road</b>   |  | d. STREET ADDRESS<br><b>5316 Oakland Road</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               |   |
| 3 NAME OF DECEASED<br>(Type or print)<br><b>Anthony Fitzgerald Lucas</b><br>First Middle Last  |  | 4. DATE OF DEATH<br><b>April 6, 1967</b><br>Month Day Year   |   |
| 5 SEX<br><b>Male</b>   | 6 COLOR OR RACE<br><b>White</b>  | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                       | 8 DATE OF BIRTH<br><b>7-21-1889</b><br>9 AGE (In years last birthday)<br><b>77</b> yrs  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Engineer</b>   | 11 BIRTHPLACE (County & State, or foreign country)<br><b>Washington, D.C.</b><br>12 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |
| 13. FATHER'S NAME<br><b>Anthony F. Lucas</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Caroline FitzGerald</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><b>Yes 1919-1919</b>   |  | 16 SOCIAL SECURITY NO<br><b>577-36-8292-A/</b><br>17 INFORMANT<br><b>Ruth H. Lucas, See Item No.2.</b><br>Address  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cancer of prostate gland</b><br>177X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____ |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>14 years</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>arteriosclerotic cardiac disease</b>  |  |  | 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                              |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |   |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>  | 20d INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>February 1, 1967</b> , to <b>April 6, 1967</b> , that (I) (we) last saw the deceased alive on <b>March 29 1967</b> , and that death occurred at <b>2:45 AM</b> , from causes on and on the date stated above.                       |  |  |   |
| 22a. SIGNATURE<br><b>Alban W. Eger</b>   |  | 22b. DATE SIGNED<br><b>April 6, 1967</b><br>M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Alban W. Eger</b>   |  | 22d. ADDRESS<br><b>1801 Eye Street N.W.</b><br><b>Washington, D.C.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>4-8-1967</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rock Creek Cemetery</b>   | 23d. LOCATION (City or town) (County) (State)<br><b>Washington, D.C.</b>  |
| 24. FUNERAL DIRECTOR<br><b>Joseph Gawler's Sons, Inc. Wash, D.C.</b>   |  | 25a. RECD BY REGISTRAR<br><b>APR 11 1967</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05418

CERTIFICATE OF DEATH

05418

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><u>Montgomery</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission)<br>a. STATE<br><u>Maryland</u><br>b. COUNTY<br><u>Montgomery</u>      |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Takoma Park</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Sanitarium</u><br><u>Washington Sanitarium and Hospital</u>  |  | d. STREET ADDRESS<br><u>1707 Cody Drive</u>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><u>Dr. John Henry MacDermott</u>   |  | 4. DATE OF DEATH<br>Month Day Year<br><u>11-27-1967</u>   |   |
| 5. SEX<br><u>male</u>   | 6. COLOR OR RACE<br><u>white</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>5-11-87</u>  |
| 9. AGE (In years lost birthday)<br><u>79</u> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Hospital Surgeon</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Dentistry</u>   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Massachusetts</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   |
| 13. FATHER'S NAME<br><u>John T. MacDermott</u>  |  | 14. MOTHER'S MAIDEN NAME<br><u>Katherine <del>XXXXXX</del> McGuck</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>YES</u> <u>WW 1 Army</u>   |  | 16. SOCIAL SECURITY NO.<br><u>218-38-6483</u>   |   |
| 17. INFORMANT<br><u>Helen B. MacDermott</u><br><u>XXXXXX</u>  |  | Address<br><u>1707 Cody Drive</u><br><u>Silver Spring, Md.</u>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u><br>DUE TO<br>(b) <u>Massive Myocardial Infarction, old.</u><br>DUE TO<br>(c) <u>Coronary Atherosclerosis</u>   |  | INTERVAL BETWEEN ONSET AND DEATH  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Anemia - secondary to renal hemorrhage</u>  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><u>19</u>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>April 18, 1965</u> to <u>April 27, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 26, 1967</u> , and that death occurred at <u>1:25 A.M.</u> from causes and on the date stated above. |  |   |   |
| 22a. SIGNATURE<br><u>Philip E. Jones</u>  |  | 22b. DATE SIGNED<br><u>4/27/67</u>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Philip E. Jones</u>  |  | 22d. ADDRESS<br><u>800 Pershing Drive</u><br><u>Silver Spring, Md.</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 23b. DATE THEREOF<br><u>May 5-1-67</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Parklawn Cemetery</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>Rockville, Maryland</u> |
| 24. FUNERAL DIRECTOR<br><u>Glen Carter Colonials</u><br><u>Warner E. Pumprey, Inc.</u>  |  | 25a. REC'D BY REGISTRAR<br><u>Charles Judge</u>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  | DATE<br><u>MAY 1 1967</u>   |   |



05413

CERTIFICATE OF DEATH

05417

|  |  |  |  |
|--|--|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  | 2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>              |  |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  | c LENGTH OF STAY IN 1b <u>40 days</u>  | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>   |  | d. STREET ADDRESS <u>8110 Hammond Ave.</u>   |  |
| 3 NAME OF DECEASED (Type or print) <u>Margaret E. Macklin</u>  |  | 4. DATE OF DEATH <u>April 30 1967</u>  |  |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>W</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>7/3/1886</u>                                      |
| 9 AGE (In years last birthday) <u>80</u> yrs   |  | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min  |  |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>  |  | 10b KIND OF BUSINESS OR INDUSTRY <u>at home</u>  |  |
| 11 BIRTHPLACE (County & State, or foreign country) <u>Willowdale, Pa</u>   |  | 12 CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  |
| 13. FATHER'S NAME <u>John Mc Crea</u>  |  | 14. MOTHER'S MAIDEN NAME <u>Susan Jane Crookham</u>  |  |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>   |  | 16. SOCIAL SECURITY NO.  |  |
| 17 INFORMANT <u>Daughter, Mrs Helen M Burns</u>  |  | Address <u>Same as above</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>CARCINOMA OF COLON</u><br><u>1958</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |  |  |  |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c TIME OF INJURY Month, Day, Year<br>Hour 'a.m. p.m. <u>19</u>   | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)  | 20f (City or town) (County) (State)                                  |
| 21 I certify that (I) (this hospital) attended the deceased from <u>1/15</u> , 19 <u>60</u> , to <u>4/30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/29</u> 19 <u>67</u> , and that death occurred at <u>1:40 P.M.</u> , from causes and on the date stated above.  |  |  |  |
| 22a SIGNATURE <u>John E. Everett</u> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>   |  | 22b. DATE SIGNED <u>Apr. 30. 1967</u>  |  |
| 22c PHYSICIAN'S NAME (Type) <u>JOHN E. EVERETT</u>   |  | 22d ADDRESS <u>9400 CONN. AVE KENSINGTON MD</u>  |  |
| 23a BURIAL, CREMATION, or other disposal (Specify)   | 23b DATE THEREOF <u>May 3, 1967</u>  | 23c NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>   | 23d LOCATION (City or Town) (County) (State) <u>Colmar Manor Md.</u> |
| 24. FUNERAL DIRECTOR <u>Charles J. Judge</u>   |  | 25a. RECEIVED BY REGISTRAR <u>W. H. D. C</u> 25b REGISTRAR'S SIGNATURE <u>Charles J. Judge</u>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MAY 2 1967





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M-1-67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05420

05418

|   |                              |  |  |
|---|------------------------------|--|--|
| 1 PLACE OF DEATH<br>a COUNTY <u>Montgomery</u> MARYLAND   |                              | 2 USUAL RESIDENCE (Where deceased lived if institut on Residence before admission)<br>o STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>                   |  |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>   |                              | c LENGTH OF STAY IN b<br><u>10 years</u>   |  |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>2315 Blue Ridge Ave. Opt. 15</u>  |                              | d STREET ADDRESS<br><u>2315 Blue Ridge Ave.</u>  |  |
| 3 NAME OF DECEASED<br>(Type or print) <u>Maybelle Jeanne Maddox</u>   |                              | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>13</u> Year <u>1967</u>  |  |
| 5 SEX<br><u>Fe.</u>   | 6 COLOR OR RACE<br><u>W.</u> | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><u>10 Sept 1896</u> |
| 9 AGE (In years, last birthday)<br><u>70</u> yrs  |                              | IF UNDER 1 YEAR<br>Months <u>13</u> Days <u>19</u> Hours <u>67</u> Min   |  |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Resident Manager</u>   |                              | 10b KIND OF BUSINESS OR INDUSTRY<br><u>Ap't. House</u>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Mobile, Alabama</u>   |                              | 12 CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13 FATHER'S NAME<br><u>Unknown</u>  |                              | 14 MOTHER'S M A DEN NAME<br><u>Unknown</u>   |  |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or "unknown") (If yes give war or dates of service)<br><u>No</u> <u>None</u>  |                              | 16 SOCIAL SECURITY NO.<br><u>215-1612234</u>   |  |
| 17 INFORMANT<br><u>Mrs. Ellen L. Sherwood</u>   |                              | Address <u>Silver Spring, Md. 807 Lanarway</u>   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage Massive</u><br>DUE TO<br>(b) <u>Arterio Sclerosis Severe</u><br>DUE TO<br>(c) <u>331X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |                              | INTERVA BETWEEN ONSET AND DEATH<br><u>20 days</u><br><u>Years</u>  |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                              | 19 WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                              | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c TIME OF INJURY Month, Day Year<br>Hour a.m. <u>19</u> p.m.  |                              | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work  |  |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)  |                              | 20f (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                              |  |  |
| ACTUAL SIGNATURE<br><u>John G. Ball</u>   |                              | 22. DATE SIGNED<br><u>4/14/67</u>  |  |
| EXAMINER'S NAME Type)<br><u>John G. Ball, M.D.</u>  |                              | Address (Street, city, town, or county)<br><u>7936 Old Georgetown Rd. Bethesda, Md.</u>  |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify)  |                              | 23b DATE THEREOF<br><u>18 Apr 1967</u>   |  |
| 23c NAME OF CEMETERY OR CREMATORY<br><u>Arlington National Cem.</u>   |                              | 23d LOCATION (City or town) (County) (State)<br><u>Arlington, Virginia</u>   |  |
| 24 FUNERAL DIRECTOR<br><u>Warner E. Pembrey, Inc.</u>   |                              | 25a REC'D BY REG. STRAP<br><u>APR 18 1967</u>  |  |
| 25b REC'D BY REG. STRAP<br><u>Charles Judge</u>   |                              | 25c REC'D BY REG. STRAP<br><u>Charles Judge</u>  |  |



05421

## CERTIFICATE OF DEATH

05419

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
CLEANED, WITH DR. JOHN ROBERT CONNOR

|  |                                  |   |                                   |  |   |  |   |
|--|----------------------------------|---|-----------------------------------|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONT GOMERY</u> MARYLAND   |                                  |   |                                   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>MONT GOMERY</u> |   |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>   |                                  | c. LENGTH OF STAY IN 1b<br><u>23 1/4 hrs</u>  |                                   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Wheaton</u>   |   |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Holy Cross Hospital of Silver Spring</u>  |                                  |   |                                   | d. STREET ADDRESS<br><u>2308-BL Bridge Ave Apr 20</u>  |   |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>William</u> Middle <u>C</u> Last <u>MANZER</u>   |                                  |   |                                   | 4. DATE OF DEATH<br>Month <u>4</u> Day <u>22</u> Year <u>1967</u>  |   |  |   |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>8/6/96</u> | 9. AGE (In years last birthday)<br><u>70</u> yrs.  | 10. IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> |  | 11. IF UNDER 24 HRS<br>Hours <u>  </u> Min. <u>  </u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>  </u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Woodward &amp; Lothrop</u>  |                                   | 11. BIRTHPLACE (County & State, or foreign country)<br><u>New Jersey</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                       |   |
| 13. FATHER'S NAME<br><u>William C. Manzer</u>  |                                  |   |                                   | 14. MOTHER'S MAIDEN NAME<br><u>Harriet Astbury</u>   |   |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)<br><u>No</u>  |                                  | 16. SOCIAL SECURITY NO<br><u>334-10-3337</u>  |                                   | 17. INFORMANT<br>Address <u>Baltimore</u><br><u>Polina St. Clair Funeral Home in Baltimore</u>   |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CANCER OF LUNG</u><br><u>163X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>  </u><br>(c) <u>  </u> |                                  |   |                                   |  |   |  | INTERVIEW BETWEEN ONSET AND DEATH<br><u>7 MONTH</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |                                   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |                                   |  |   |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>4/21</u> , 19 <u>67</u> , to <u>4/22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/21</u> , 19 <u>67</u> , and that death occurred at <u>12:30</u> M, from causes and on the date stated above.        |                                  |   |                                   |  |   |  |   |
| 22a. SIGNATURE<br><u>David Goldenberg</u>  |                                  |   |                                   | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>           |   | 22b. DATE SIGNED<br><u>4/22/67</u>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>DAVID GOLDENBERG</u>  |                                  |   |                                   | 22d. ADDRESS<br><u>10620 CAMDEN, SIL SPRING, MD</u>  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |                                  | 23b. DATE THEREOF<br><u>Apr 22, 1967</u>  |                                   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Greenwood Cemetery</u>  |   | 23d. LOCATION (City or Town) (County) (State)<br><u>Bethesda, Dist. Columbia</u> |   |
| 24. FUNERAL DIRECTOR<br><u>Clark E. Wilson</u>   |                                  | ADDRESS<br><u>8434 Leesville Trg, Silver Spring, Md</u>   |                                   | 25a. REC'D BY REGISTRAR<br><u>APR 27 1967</u>  |   | 25b. REGISTRAR'S SIGNATURE<br><u>John Charles Judge</u>                          |   |



## CERTIFICATE OF DEATH

35422

05420

|  |                              |   |                                     |
|--|------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> MARYLAND  |                              | 2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>                |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SILVER SPRING</b>   |                              | c. LENGTH OF STAY IN 1b<br><b>6 YRS</b>   |                                     |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>10011 FOREST GROVE DR. SILVER SPRING MD</b>   |                              | e. STREET ADDRESS<br><b>10011 FOREST GROVE DR. SILVER SPRING</b>  |                                     |
| 3. NAME OF DECEASED<br>(Type or print) <b>ROBERT GUSTON MARMADUKE</b>  |                              | 4. DATE OF DEATH<br>Month <b>APRIL</b> Day <b>17</b> Year <b>1967</b>   |                                     |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12/20/74</b> |
| 9. AGE (In years last birthday)<br><b>92 yrs</b>   |                              | 10. IF UNDER 1 YEAR<br>Months <b>17</b> Days <b>19</b> Hours <b>67</b> Min.   |                                     |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>ROAD CONSTRUCTION</b>  |                              | 11b. KIND OF BUSINESS OR INDUSTRY<br><b>STATE OF VA</b>   |                                     |
| 11c. BIRTHPLACE (County & State, or foreign country)<br><b>WESTMORLAND, VIRGINIA</b>   |                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                     |
| 13. FATHER'S NAME<br><b>ROBT. VENTON MARMADUKE</b>   |                              | 14. MOTHER'S MAIDEN NAME<br><b>OLIVIA SANDERS</b>   |                                     |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>  |                              | 16. SOCIAL SECURITY NO<br><b>329-18-4857</b>  |                                     |
| 17. INFORMANT<br><b>DAUGHTER - MRS G. SANDERS</b>  |                              | Address <b>10011 FOREST GROVE DR. SILVER SPRING MD</b>  |                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b><br>DUE TO <b>4200</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>WITH TERMINAL PNEUMONIA</b><br>DUE TO<br>(c) |                              | INTERVAL BETWEEN ONSET AND DEATH<br><b>20 YRS</b><br><b>3 DAYS</b>  |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>CONGESTIVE HEART FAILURE</b>  |                              | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>NO</b>  |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                     |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. <b>19</b> p.m.   |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                              | 20f. (City or town) (County) (State)  |                                     |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1962</b> , to <b>4/17</b> , 1967, that (I) (we) last saw the deceased alive on <b>4/17</b> , 1967, and that death occurred at <b>8:00 PM</b> , from causes and on the date stated above.  |                              |   |                                     |
| 22a. SIGNATURE<br><b>Henry W. Stout MD</b>   |                              | 22b. DATE SIGNED<br><b>4/17/67</b>  |                                     |
| 22c. PHYSICIAN'S NAME (Type)<br><b>HENRY W. STOUT MD</b>   |                              | 22d. ADDRESS<br><b>10011 GEORGIA AVE SILVER SPRING</b>  |                                     |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                              | 23b. DATE THEREOF<br><b>Apr 20, 1967</b>  |                                     |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>   |                              | 23d. LOCATION (City or Town) (County) (State)<br><b>Suitland, Maryland</b>  |                                     |
| 24. FUNERAL DIRECTOR<br><b>Charles E. Humphrey, Inc. Silver Spring, Md.</b>  |                              | 25a. REC'D BY REGISTRAR<br><b>APR 20 1967</b>   |                                     |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles E. Judge</b>  |                              |   |                                     |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



05423

## CERTIFICATE OF DEATH

05421

|  |                                 |  |   |
|--|---------------------------------|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |                                 | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Virginia</b> b. COUNTY <b>Falls Church</b>            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (rural)</b>  |                                 | c. LENGTH OF STAY IN lb<br><b>7 days</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Naval Hospital</b>  |                                 | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print)<br><b>George Thomas MARSHALL</b>   |                                 | 4 DATE OF DEATH<br>Month <b>April</b> Day <b>3</b> Year <b>19 67</b>   |   |
| 5 SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Cauc</b> | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><b>Dec. 14, 1966</b> |
| 9. AGE (In years last birthday) yrs.<br><b>3</b>   |                                 | 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)<br><b>N/A</b>   |   |
| 10b. KIND OF BUSINESS OR INDUSTRY<br><b>N/A</b>  |                                 | 11 BIRTHPLACE (County & State) <b>Force Maryland</b>   |   |
| 13. FATHER'S NAME<br><b>Robert M. Marshall</b>   |                                 | 14. MOTHER'S MAIDEN NAME<br><b>Grace Evelyn Harrison</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><b>No</b>  |                                 | 16. SOCIAL SECURITY NO<br><b>N/A</b>   |   |
| 17. INFORMANT <b>Falls Church</b> Address <b>Virginia</b><br><b>CDR Robert M. Marshall, 2545 Hillsman St.</b>  |                                 | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)<br><b>751.2</b> DUE TO<br><b>Meningomyelocele with hydrocephalus and ventriculitis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO<br>(c)                              |                                 | INTERVAL BETWEEN ONSET AND DEATH   |   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                 |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                                 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                 | 20f. (City or town) (County) (State)   |   |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 28</b> , 19 <b>67</b> , to <b>April 3</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 3</b> , 19 <b>67</b> , and that death occurred at <b>230A</b> M, from causes and on the date stated above. |                                 |  |   |
| 22a. SIGNATURE<br><b>Jerry J. Tomasovic</b>  |                                 | 22b. DATE SIGNED<br><b>April 3, 1967</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Jerry J. Tomasovic, M. D.</b>   |                                 | 22d. ADDRESS<br><b>Naval Hospital, Bethesda, Md.</b>   |   |
| 23a. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                 | 23b. DATE THEREOF<br><b>4/5/67</b>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National Cemetery</b>   |                                 | 23d. LOCATION (City or Town) (County) (State)<br><b>Arlington Virginia</b>   |   |
| 24. FUNERAL DIRECTOR<br><b>Falls Church</b>  |                                 | 24a. REG. BY <b>10 1967</b>  |   |
| Falls Church Funeral Home, 1102 West Broad St.   |                                 | DATE   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

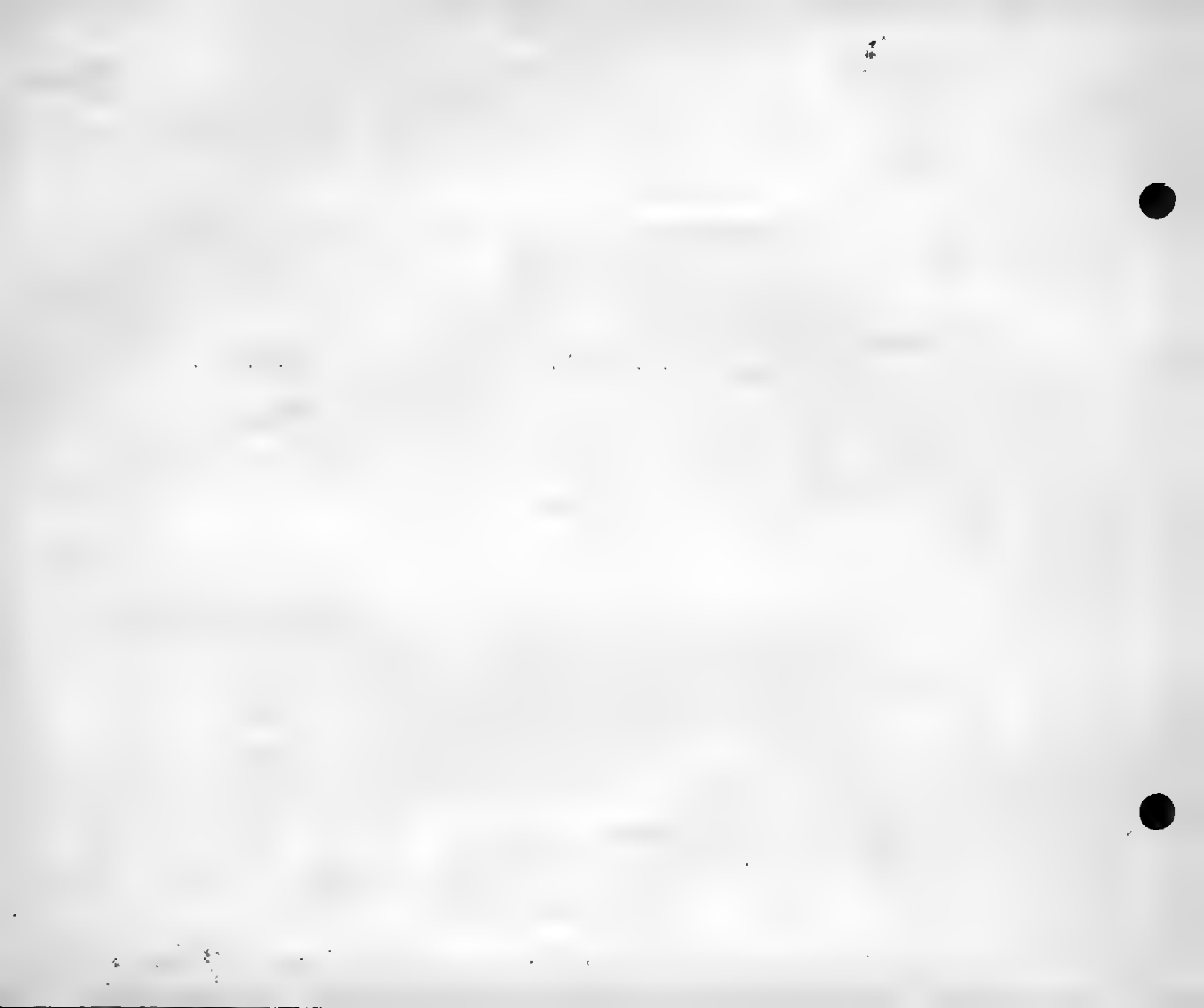
05424

CERTIFICATE OF DEATH

05422

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>              |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>TAKOMA PARK</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SILVER SPRING</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>WASHINGTON SANITARIUM AND HOSPITAL</b>   |  | d. STREET ADDRESS<br><b>9304 PINEY BRANCH</b>  |   |
| 3. NAME OF DECEASED (Type or print) <b>MR. JULIAN WOODROW MAY</b>   |  | 4. DATE OF DEATH<br>Month <b>APRIL</b> Day <b>5</b> Year <b>1967</b>   |   |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>SEPT. 20, 1915</b>                                       |
| 9. AGE (In years lost birth day)<br><b>51</b> yrs   |  | 10. IF UNDER 1 YEAR<br>Months <b>5</b> Days <b>1</b> Hours <b>1</b> Min.   | 11. IF UNDER 24 HRS.<br>Hours <b>1</b> Min.                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>GOVERNMENT worker</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Gov't.</b>  |   |
| 11. BIRTHPLACE (County & State or foreign country)<br><b>MARYLAND</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>JOHN H. MAY</b>   |  | 14. MOTHER'S M maiden name<br><b>CLAIRE CONLEY</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes WW II</b>   |  | 16. SOCIAL SECURITY NO.<br><b>214-14-8666</b>  |   |
| 17. INFORMANT<br><b>Chart Hospital Records</b>  |  | Address  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary artery embolus</b><br>DUE TO (b) <b>Embolization of legs</b><br>DUE TO (c) <b>Arteriosclerotic heart disease</b>                           |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>4 hours</b><br><b>Unknown</b><br><b>1 yr</b>   |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) <del>(his hospital)</del> attended the deceased from <b>March 27, 1967</b> , to <b>April 5, 1967</b> , that (I) (we) lost saw the deceased alive on <b>April 5, 1967</b> , and that death occurred at <b>10 A.M.</b> , from causes on and the date stated above. |  |  |   |
| 22a. SIGNATURE<br><b>Clara H. Traum</b>   |  | 22b. DATE SIGNED<br><b>April 6, 1967</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. Traum</b>  |  | 22d. ADDRESS<br><b>8237 Ringo Ave Silver Spring Maryland</b>   |   |
| 23a. BURIAL, CREMATION, or other disposition (Specify)  | 23b. DATE THEREOF<br><b>4/10/67</b>  | 23c. NAME OF CEMETERY OR REPOSITORY<br><b>Baltimore National</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Baltimore Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>Francis Gasch's Sons Hyattsville, Md.</b>  |  | 25a. REC'D BY REGISTRAR<br><b>APR 10 1967</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>William Judge</b>  |  |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



05425

## CERTIFICATE OF DEATH

05423

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

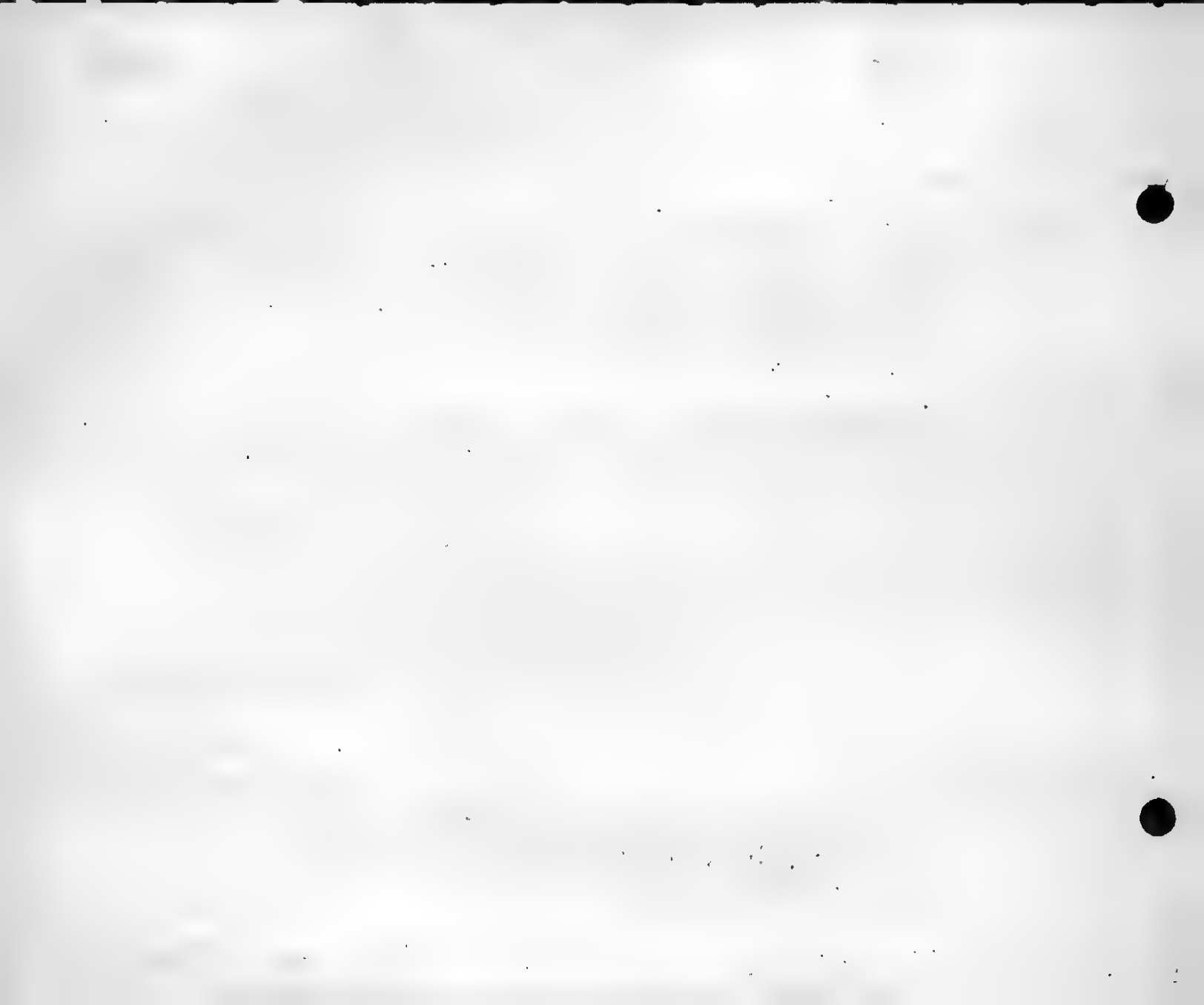
|  |   |  |  |
|--|---|--|--|
| 1 PLACE OF DEATH<br>a COUNTY <u>MONTGOMERY</u> MARYLAND  |   | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>             |  |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>   |   | c LENGTH OF STAY IN 1b <u>5 days</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross of Silver Spring</u>  |   | d. STREET ADDRESS <u>1507 Crest Rd.</u>  |  |
| 3. NAME OF DECEASED (Type or print) <u>James W. McCarrick</u>  |   | 4. DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>1967</u>   |  |
| 5 SEX <u>M.</u>  | 6 COLOR OR RACE <u>White</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>3/30/91</u>                                       |
| 9. AGE (in years last birthday) <u>76</u> yrs.   |   | IF UNDER 1 YEAR Months Days Hours Min.   |  |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>   |   | 10b KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>  |  |
| 11 BIRTHPLACE (County & State, or foreign country) <u>Macon, Georgia</u>   |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>Patrick Mc Carrick</u>  |   | 14. MOTHER'S MAIDEN NAME <u>Mary Cannon</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WWII</u>   |   | 16 SOCIAL SECURITY NO. <u>904-05-5034</u>  |  |
| 17. INFORMANT <u>Earlean Mc Carrick</u>  |   | Address <u>1507 Crest Road Silver Spring, Md</u>   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u><br>DUE TO (b) <u>Chronic Coronary Heart Disease</u><br>DUE TO (c) <u>2 years</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   | INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Bronchitis &amp; Emphysema</u>   |   | 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II or item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                 |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan 19 67</u> to <u>April 19 67</u> that (I) (we) last saw the deceased alive on <u>April 28 1967</u> and that death occurred at <u>1507 Crest Rd</u> from causes and on the date stated above.   |   |  |  |
| 22a. SIGNATURE <u>John J. Curry</u> M.D.   |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                                     | 22b. DATE SIGNED <u>4/28/67</u>                                      |
| 22c. PHYSICIAN'S NAME (Type) <u>John J. Curry</u>  |   | 22d. ADDRESS <u>10620 Georgetown, Md</u>   |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-Burial</u>   | 23b DATE THEREOF <u>May 2, 1967</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Roch's Cemetery</u>  | 23d LOCATION (City or Town) (County) (State) <u>New Orleans, La.</u> |
| 24. FUNERAL DIRECTOR <u>Glen Carter, 8434 Georgia Avenue, Silver Spring, Md.</u>   |   | 25a. REC'D BY REGISTRAR <u>MAY 1 1967</u>  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>                      |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
05426 CERTIFICATE OF DEATH 05424

|   |                           |  |                                      |
|---|---------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                           | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>                  |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>   |                           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>  |                                      |
| c. LENGTH OF STAY IN 1b <u>1 month</u>  |                           | d. STREET ADDRESS <u>8200 N.H. Ave</u>   |                                      |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Oakhaven Convalescent Home</u>  |                           | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |
| 3. NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>F.</u> Last <u>Mc Chesney</u>  |                           | 4. DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>1967</u>   |                                      |
| 5. SEX <u>F.</u>  | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct 20, 1872</u> |
| 9. AGE (in years last birthday) <u>94</u> yrs.  |                           | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bureau of Pr. + Engraving U.S. Govt</u>  |                           | 10b. KIND OF BUSINESS OR INDUSTRY  |                                      |
| 11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>   |                           | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>   |                                      |
| 13. FATHER'S NAME <u>Joseph Nicholson</u>   |                           | 14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth</u>   |                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)   |                           | 16. SOCIAL SECURITY NO. <u>-</u>   |                                      |
| 17. INFORMANT Address <u>Silver Spring Md.</u><br><u>Mrs. May, 8200 New Hampshire Ave.</u>  |                           |  |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiovascular failure</u><br>DUE TO (b) <u>Old age, Cachexia + weakness, Bedridden</u><br>DUE TO (c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                           | INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u>   |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                           | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)   |                                      |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>   |                           | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)   |                                      |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1, 1967</u> to <u>4/28/1967</u> , that (I) (we) last saw the deceased alive on <u>4/27/1967</u> and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above.  |                           |  |                                      |
| 22a. SIGNATURE <u>Chas H W. Lohman</u>  |                           | 22b. DATE SIGNED   |                                      |
| 22c. PHYSICIAN'S NAME (Type) <u>Chas H W. Lohman</u>  |                           | 22d. ADDRESS <u>7401 Blue Rd NW</u>  |                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |                           | 23b. DATE THEREOF  |                                      |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Fort Detrick</u>  |                           | 23d. LOCATION (City, town or county) (State) <u>Blacksburg Va</u>  |                                      |
| 24. FUNERAL DIRECTOR <u>W. H. Chamberlain, Inc</u>  |                           | 25a. REC'D BY REGISTRAR <u>MAY 4 1967</u>  |                                      |
| ADDRESS <u>86 S. 5th Ave</u>  |                           | 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>   |                                      |



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05427

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05425

|   |                               |  |                                    |
|---|-------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>   |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Takoma Park</u>  |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Burtons-Ville</u>   |                                    |
| c. LENGTH OF STAY IN TB<br><u>5 days</u>  |                               | d. STREET ADDRESS<br><u>4519 Sandy Spring Rd</u>   |                                    |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Washington Sanitarium</u>  |                               | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                    |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>John</u> Middle <u>Nine</u> Last <u>McClanahan</u>   |                               | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>15</u> Year <u>1967</u>  |                                    |
| 5. SEX<br><u>M.</u>   | 6. COLOR OR RACE<br><u>W.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><u>3/26/02</u> |
| 9. AGE (In years lost birthday)<br><u>65</u> yrs  |                               | 10. IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>   |                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>gardmaster</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Railroad</u>   |                                    |
| 11. BIRTHPLACE (State or foreign country)<br><u>Kentucky</u>  |                               | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |                                    |
| 13. FATHER'S NAME<br><u>David P. McClanahan</u>   |                               | 14. MOTHER'S MAIDEN NAME<br><u>Emma Overbury</u>   |                                    |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <u>1919-1921</u> (If yes give war or dates of service)   |                               | 16. SOCIAL SECURITY NO<br><u>71814-9712</u>  |                                    |
| 17. INFORMANT<br><u>Mr. John P. McClanahan</u>  |                               | Address <u>  </u>  |                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Intra-Brain Hemorrhage &amp; Thrombosis</u><br>DUE TO <u>Middle Cerebral Artery Left</u><br>(b) <u>Coronary Insufficiency Severe</u><br>DUE TO <u>Arteriosclerosis generalized severe</u><br>(c) <u>  </u> |                               | INTERVAL BETWEEN ONSET AND DEATH<br><u>4 days</u><br><u>4 years</u><br><u>years</u>  |                                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Anesthesia for Manipulation of free Shoulder</u>  |                               | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                    |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/><br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>General anesthesia increased strain on Vascular system</u>  |                               | 20c. T.M. OF INJURY Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>   |                                    |
| 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |                               | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>  </u>  |                                    |
| 20f. (City or town)<br><u>  </u>  |                               | 20g. (County)<br><u>  </u>   |                                    |
| 20h. (State)<br><u>  </u>   |                               | 21. I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                    |
| ACTUAL SIGNATURE<br><u>John S. Bull</u> M.D.  |                               | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |                                    |
| EXAMINER'S NAME (Type)<br><u>John S. Bull</u>   |                               | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |                                    |
| 22. DATE SIGNED<br><u>4/15/67</u>   |                               | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |                                    |
| Address (Street, city, town, or county)<br><u>  </u>  |                               | 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                    |
| 23b. DATE THEREOF<br><u>4-18-67</u>   |                               | 23c. NAME OF CEMETERY OR CREMATORY<br><u>American Cem</u>  |                                    |
| 23d. LOCATION (City or town)<br><u>Burtons-Ville Md</u>   |                               | 23e. (County)<br><u>  </u>   |                                    |
| 23f. (State)<br><u>  </u>   |                               | 23g. REC'D BY REGISTRAR<br><u>Charles Judge</u>  |                                    |
| 23h. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |                               | DATE<br><u>APR 20 1967</u>   |                                    |





05428

## CERTIFICATE OF DEATH

05426

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Montgomery</u>            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Takoma Park</u>  |                                  | c. LENGTH OF STAY IN Ib<br><u>D.O.A.</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Washington Sanitarium and Hospital</u>   |                                  | d. STREET ADDRESS<br><u>508 Wayne Avenue</u>  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Loretta</u> Middle <u>E.</u> Last <u>Mc Donnell</u>  |                                  | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>4</u> Year <u>1967</u>  |   |
| 5. SEX<br><u>female</u>   | 6. COLOR OR RACE<br><u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>April 25, 1905</u> |
| 9. AGE (In years lost birthday) yrs.<br><u>61</u>   |                                  | IF UNDER 1 YEAR<br>Months <u>4</u> Days <u>19</u> Hours <u>67</u>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Financial Sec. &amp; Treas.</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Fidelity Properties</u>   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Pennsylvania</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   |
| 13. FATHER'S NAME<br><u>John M. Crawley</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Katherine Windle</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |                                  | 16. SOCIAL SECURITY NO<br><u>Yes</u>  |   |
| 17. INFORMANT<br><u>James A. Mc Donnell</u>   |                                  | Address<br><u>508 Wayne Avenue Silver Spring, Md.</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrhythmia</u><br>DUE TO (b) <u>coronary thrombosis</u><br>DUE TO (c) <u>coronary atherosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br><u>4401</u> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>few minutes</u><br><u>few minutes</u><br><u>7 yrs</u>  |   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Diabetes mellitus onset 1954</u>   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June 20, 1957</u> , to <u>April 4, 1967</u> , that (I) (we) last saw the deceased alive on <u>Mar 29, 1967</u> , and that death occurred at <u>250 A.M.</u> from causes and on the date stated above.  |                                  |   |   |
| 22a. SIGNATURE<br><u>Michael M. Healy</u>   |                                  | 22b. DATE SIGNED<br><u>4/4/67</u>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>MICHAEL M. HEALY</u>   |                                  | 22d. ADDRESS<br><u>WASHINGTON CLINIC, WASH. D.C.</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 23b. DATE THEREOF<br><u>Apr 8, 1967</u>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mt. Olivet Cemetery</u>  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><u>Washington, D. C.</u>   |   |
| 24. FUNERAL DIRECTOR<br><u>John B. Thomas</u><br><u>Warner E. Pumphrey, Inc.</u>  |                                  | 25a. REC'D BY REGISTRAR<br>DATE <u>APR 7 1967</u>   |   |
| ADDRESS<br><u>8434 Georgia Avenue Silver Spring, Md.</u>  |                                  | 25b. REGISTRAR'S SIGNATURE<br><u>J. Charles Jones</u>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



05423

## CERTIFICATE OF DEATH

05427

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>Prince George's</i> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><i>Maryland</i> b. COUNTY<br><i>Prince George's</i>    |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Greenbelt</i>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Greenbelt</i>  |   |
| c. LENGTH OF STAY IN 1b<br><i>2. 0. 4.</i>   |   | d. STREET ADDRESS<br><i>7107 14th Avenue</i>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><i>Washington Sanitarium and Hospital</i>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><i>Peter</i>   |   | 4. DATE OF DEATH<br>Month <i>April</i> Day <i>20</i> Year <i>1967</i>   |   |
| 5. SEX<br><i>Male</i>  | 6. COLOR OR RACE<br><i>White</i>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>July 20, 1921</i>  |
| 9. AGE (In years last birthday)<br><i>45 yrs</i>   |   | 10. IF UNDER 1 YEAR<br>Months <i>2</i> Days <i>10</i> Hours <i>10</i> Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Accountant</i>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>U. S. Workers</i>   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><i>Penna.</i>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |   |
| 13. FATHER'S NAME<br><i>Peter G. McGuck, Sr.</i>   |   | 14. MOTHER'S MAIDEN NAME<br><i>Rose Burke</i>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><i>No</i>   |   | 16. SOCIAL SECURITY NO.<br><i>175-12-9578</i>   |   |
| 17. INFORMANT<br><i>Regina McGuck</i>  |   | Address<br><i>7107 14th Ave NE<br/>Greenbelt, Maryland</i>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i><br>DUE TO <i>4201</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <i>Cor. Ar. Dis</i><br>DUE TO<br>(c) |   | INTERVAL BETWEEN ONSET AND DEATH<br><i>2 months</i>   |   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <i>19</i> p.m.   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <i>July</i> , 1967, to <i>Apr 20</i> , 1967, that (I) (we) last saw the deceased alive on <i>Apr 18</i> , 1967, and that death occurred at <i>8:00 A.M.</i> , from causes and on the date stated above.  |   |   |   |
| 22a. SIGNATURE<br><i>James J. Foster</i> M.D.  |   | 22b. DATE SIGNED<br><i>4/20/67</i>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><i>James J. Foster</i>   |   | 22d. ADDRESS<br><i>1746 K St N.W.</i>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   | 23b. DATE THEREOF<br><i>Apr 21, 1967</i>  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Gate of Heaven Cemetery</i>  | 23d. LOCATION (City or Town) (County) (State)<br><i>Silver Spring, Maryland</i> |
| 24. FUNERAL DIRECTOR<br><i>Harriet E. P. Johnson, Inc.</i>   |   | 25a. REC'D BY REGISTRAR<br>DATE<br><i>APR 27 1967</i>   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles J. Young</i>                           |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



05428

05430

## CERTIFICATE OF DEATH

|  |  |   |  |
|--|--|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring, Md.</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring, Md.</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Colonial Villa Nursing Home</u>   |  | d. STREET ADDRESS<br><u>3304 Runnymede Place N.W.</u>   |  |
| 3 NAME OF DECEASED<br>(Type or print)<br>First <u>Edna</u> Middle <u>Webb</u> Last <u>Miles</u>  |  | 4 DATE OF DEATH<br>Month <u>4</u> Day <u>22</u> Year <u>1967</u>  |  |
| 5 SEX<br><u>F</u>  | 6. COLOR OR RACE<br><u>W</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><u>4-20-82</u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>---</u>   | 9. AGE (In years lost birthday)<br><u>85</u> yrs                                       |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Maryland</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>James A. Webb</u>  |  | 14. MOTHER'S MAIDEN NAME<br><u>Elizabeth Snyder</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>---</u>  |  | 16. SOCIAL SECURITY NO<br><u>---</u>  |  |
| 17. INFORMANT<br><u>Walter Miles, Jr. Sec Item #2</u>  |  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Heart Failure</u><br>DUE TO<br>(b) <u>Pneumonia</u><br>DUE TO<br>(c) <u>---</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 dyc</u>                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>Parkinson's Disease</u>   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u><br>p.m.  | 20d. INJURY OCCURRED<br>While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>2/26, 1967</u> to <u>4-22, 1967</u> , that (I) ( <del>was</del> ) last saw the deceased alive on <u>4-20, 1967</u> , and that death occurred at <u>2:25 AM</u> , from causes and on the date stated above.                         |  |   |  |
| 22a. SIGNATURE<br><u>R. H. Sandstrom</u>   |  | 22b. DATE SIGNED<br><u>4-22-67</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>R. H. Sandstrom MD</u>  |  | 22d. ADDRESS<br><u>7701 Carroll Ave Takoma Park Md</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 23b. DATE THEREOF<br><u>4-25-1967</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Rock Creek, Cemetery</u>   | 23d. LOCATION (City or Town) (County) (State)<br><u>Washington, D.C.</u>               |
| 24. FUNERAL DIRECTOR<br><u>Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Washington DC.</u>   |  | 25a. DATE OF REGISTRATION<br><u>APR 26 1967</u>   |  |
|  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>05431</p> </div> <div> <p>CERTIFICATE OF DEATH</p> <p>05429</p> </div> </div>  |  |   |  |  |  |   |  |   |   |   |  |   |  |
|---|--|---|--|--|--|---|--|---|---|---|--|---|--|
| <p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Montgomery</u> MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and the nearest town) <u>Takoma Park</u></p> <p>c. LENGTH OF STAY IN 1b <u>5 1/2 yrs</u></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Oakhaven Convalescent Home</u></p>  |  |   |  |  |  | <p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and the nearest town) <u>Silver Spring</u></p> <p>d. STREET ADDRESS <u>8825 Glenville</u></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> |  |   |   |   |  |   |  |
| <p>3. NAME OF DECEASED (Type or print)</p> <p>First <u>Oscar</u> Middle <u>R.</u> Last <u>Miller</u></p>  |  | <p>4. DATE OF DEATH</p> <p>Month <u>April</u> Day <u>8</u> Year <u>1967</u></p> |  | <p>5. SEX <u>M</u></p>   |  | <p>6. COLOR OR RACE <u>White</u></p>  |  | <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p> |   | <p>8. DATE OF BIRTH <u>Oct 12 1878</u></p>                |  | <p>9. AGE (In years last birthday) <u>88</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.</p> |  |
| <p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postman</u></p>   |  |   |  | <p>10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. gov't</u></p>   |  | <p>11. BIRTHPLACE (County &amp; State, or foreign country) <u>Virginia</u></p>  |  |   | <p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u></p> |   |  |   |  |
| <p>13. FATHER'S NAME <u>Miller</u></p>  |  |   |  |  |  | <p>14. MOTHER'S MAIDEN NAME <u>Mary Ryan</u></p>  |  |   |   |   |  |   |  |
| <p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes: give war or dates of service) <u>No</u></p>   |  |   |  | <p>16. SOCIAL SECURITY NO. <u>577-36-1414</u></p>  |  | <p>17. INFORMANT <u>Mrs. Helen Colvin</u> Address <u>841 1st Ave. Silver Spring Md.</u></p>   |  |   |   |   |  |   |  |
| <p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart failure due to arteriosclerosis</u></p> <p>(b) <u>Old cerebral thrombosis &amp; paralysis</u></p> <p>(c) <u>Isabelia Myelitis</u></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p> |  |   |  |  |  |   |  |   |   |   |  | <p>INTERVAL BETWEEN ONSET AND DEATH</p> <p><u>3 yrs</u></p> <p><u>8-4 yrs</u></p>                             |  |
| <p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>   |  |   |  |  |  |   |  |   |   |   |  |   |  |
| <p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)</p>   |  |   |  |  |  |   |  |   |   |   |  |   |  |
| <p>20c. TIME OF INJURY Month, Day, Year</p> <p>Hour a.m. p.m. <u>19</u></p>   |  |   |  | <p>20d. INJURY OCCURRED</p> <p>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p> |  | <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>   |  | <p>20f. (City or town) (County) (State)</p>   |   |   |  |   |  |
| <p>21. I certify that (I) (this hospital) attended the deceased from <u>1/15/1967</u> to <u>4/8/1967</u>, that (I) (we) last saw the deceased alive on <u>4/8/1967</u>, and that death occurred at <u>2 P</u> M, from the causes and on the date stated above.</p>  |  |   |  |  |  |   |  |   |   |   |  |   |  |
| <p>22a. SIGNATURE <u>Chas H. Volohon</u></p>  |  |   |  |  |  |   |  |   |   |   |  | <p>22b. DATE SIGNED <u>apr 8, 1967</u></p>  |  |
| <p>22c. PHYSICIAN'S NAME (Type) <u>Chas H. Volohon</u></p>  |  |   |  |  |  | <p>22d. ADDRESS <u>7401 Bl. Rd NW Wash. DC</u></p>  |  |   |   |   |  |   |  |
| <p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>  |  |   |  | <p>23b. DATE THEREOF <u>April 11, 1967</u></p>   |  | <p>23c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Park</u></p>   |  | <p>23d. LOCATION (City, town or county) (State) <u>Falls Church, Virginia</u></p>   |   |   |  |   |  |
| <p>24. FUNERAL DIRECTOR <u>J. Arthur Walters</u></p>  |  |   |  |  |  | <p>ADDRESS <u>254 Carroll St NW Wash. DC</u></p>  |  | <p>25a. REG'D BY REGISTRAR <u>APR 13 1967</u></p>   |   | <p>25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u></p> |  |   |  |





05432

## CERTIFICATE OF DEATH

05430

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>md.</u> b. COUNTY <u>Mont</u>                       |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>  |  |
| c. LENGTH OF STAY in 1b <u>30 days</u>  |   | d. STREET ADDRESS <u>807 Grandin Ave.</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) <u>Cartee W. Mills, Sr.</u>   |   | 4. DATE OF DEATH <u>4-7-67</u>   |  |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>W</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5-21-08</u> 58 yrs.                                  |
| 10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Western Elec.</u>   |   | 11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>  |  |
| 10b. KIND OF BUSINESS OR INDUSTRY   |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>George C. Mills</u>  |   | 14. MOTHER'S MAIDEN NAME <u>Summer T. Lathram</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)   |   | 16. SOCIAL SECURITY NO <u>517-07-8535</u>  |  |
| 17. INFORMANT <u>Wife - Olive - Same</u>  |   | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral metastases</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Bronchogenic Carcinoma</u><br>(b) <u></u><br>(c) <u></u> |   |  | INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>                           |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                     |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1962</u> to <u>4-7, 1967</u> , that (I) (we) last saw the deceased alive on <u>4-6</u> 19 <u>67</u> , and that death occurred at <u>7:47</u> M, from causes and on the date stated above   |   |  |  |
| 22a. SIGNATURE <u>[Signature]</u>   |   | 22b. DATE SIGNED <u>4-7-67</u>   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>Dr. Budy</u>  |   | 22d. ADDRESS <u>809 Venus Mill Rd Rockville Mont Md</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 23b. DATE THEREOF <u>4-10-67</u>  | 23c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>   | 23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u> |
| 24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>  |   | 25a. REC'D BY REGISTRAR <u>APR 13 1967</u>   | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>                            |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |   |  |  |  |   |  |   |  |
|--|--|---|--|---|--|--|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |   |  |  |  |   |  |   |  |
| 05433  |  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |   |  |  |  | 05431   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND  |  |   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>Howard</u> ✓ |  |   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>SILVER SPRING</u>   |  |   |  | c. LENGTH OF STAY IN 1b   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>SESSUP</u>  |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>811 DALE DRIVE</u>  |  |   |  |   |  | d. STREET ADDRESS<br><u>Box 161</u>  |  |   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>GEORGE MITCHELL</u>  |  |   |  |   |  | 4. DATE OF DEATH<br>Month <u>4</u> Day <u>6</u> Year <u>1967</u>   |  |   |  |   |  |
| 5. SEX<br><u>M</u>   |  | 6. COLOR OR RACE<br><u>W</u>            |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>Sept 13 1912</u>  |  | 9. AGE (In years lost birthday) <u>54</u> yrs |  | IF UNDER 1 YEAR<br>Months Days Hours Min  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Inspector</u>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>U.S. Patent Office</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Kansas</u>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>George Robert Mitchell</u>   |  |   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Lucy Day</u>  |  |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>NO</u>   |  |   |  | 16. SOCIAL SECURITY NO<br><u>NONE</u>   |  | 17. INFORMANT<br><u>Mr. John R Mitchell</u>  |  |   |  | 902 <u>Seventh St.</u><br><u>Laurel, Md.</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute coronary insufficiency</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Coronary artery heart disease</u><br>DUE TO<br>(c)   |  |   |  |   |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.   |  |   |  |   |  |  |  |   |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |  |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |  |   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)          |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |   |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE<br><u>Belden R. Reap</u> M.D.   |  |   |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |   |  |
| EXAMINER'S NAME (Type)<br><u>BELDEN R. REAP M.D.</u>   |  |   |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |   |  |
|  |  |   |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county) <u>4-7-1967</u>                     |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE THEREOF                       |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or town) (County) (State)  |  |   |  |   |  |
| <u>BURIAL</u>  |  | <u>4-9-67</u>                           |  | <u>Christ Church</u>  |  | <u>Quilford Howard Md.</u>   |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br><u>FC Higgins</u>  |  |   |  |   |  | ADDRESS<br><u>Ellwood P. 2</u>   |  | 25d. REC'D BY REGISTRAR<br><u>APR 11 1967</u> |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

Item #9 Film #0387 4/17/67 by

35434

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Reside in hospital or institution)<br>a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u>            |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>  |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Eugene Oscar Mobley</u>  |  |  |  | 4. DATE OF DEATH Month Day Year <u>April 7 1967</u>   |  |   |  |
| 5. SEX <u>male</u>  |  | 6. COLOR OR RACE <u>white</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 8. DATE OF BIRTH <u>5/12/13</u>   |  |
| 9. AGE (in years, months, days) <u>53 yrs</u>   |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>custodian</u> |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Christman Lodge</u>  |  | 11. BIRTHPLACE (State or foreign country) <u>Mont. Co.</u>                        |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |  |  | 13. FATHER'S NAME <u>Bud Mobley</u> MOTHER'S MAIDEN NAME <u>Mary Syson</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv ice) <u>no</u>  |  |  |  | 16. SOCIAL SECURITY NO  |  | 17. INFORMANT <u>Cousin - Shirley Newman</u> Address <u>same as above</u>         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>LOBULAR PNEUMONIA, BILATERAL</u><br>DUE TO <u>1160</u><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b) <u>BURNS, 2nd + 3rd. DEGREE</u><br>STATE THE UNDERLYING CAUSE (c) <u>last.</u>   |  |  |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH <u>Weeks</u>  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>FATTY METAMORPHOSIS, LIVER</u>  |  |  |  |   |  |   | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Hebephrenic</u>   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) <u>Hebephrenic</u>  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year <u>3/20 1967</u>   |  |  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work   |  | 20e. PLACE OF INJURY (home, farm, factory, street, office bldg, etc.) <u>Home</u> |  |
| 20f. (City or town) <u>Gaithersburg</u> (County) <u>Montg</u> (State) <u>MD</u>   |  |  |  |   |  |   |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE <u>John M. Ball</u> M.D.   |  |  |  | 22. DATE SIGNED <u>4/8/67</u>   |  |   |  |
| EXAMINER'S NAME (Type) <u>John M. Ball</u>  |  |  |  | Address (Street, city, town, or county)   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL <u>Burial</u>   |  | 23b. DATE THEREOF <u>4-12-67</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Brooke Grove.,</u>  |  | 23d. LOCATION (City or Town) (County) (State) <u>Laytonsville, Md.</u>            |  |
| 24. FUNERAL DIRECTOR <u>Robert L. Surwden</u> ADDRESS <u>Rockville, Md.</u>   |  |  |  | 25a. REC'D BY REGISTRAR <u>APR 13 1967</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>                                   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body. If any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05435

CERTIFICATE OF DEATH

|  |   |  |   |
|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>   |   | d. STREET ADDRESS <u>11208 Sluway Rd.</u>  |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Ida Belle Monnie</u>  |   | 4. DATE OF DEATH Month Day Year <u>April 20 1967</u>   |   |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>W</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12/28/1883</u> 83 yrs                           |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>   |   | 9b. KIND OF BUSINESS OR INDUSTRY <u>None</u>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>  |   |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Pa.</u>   |   | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |   |
| 13. FATHER'S NAME <u>James Patton</u>  |   | 14. MOTHER'S MAIDEN NAME <u>Anna Henry</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>  |   | 16. SOCIAL SECURITY NO. <u>None</u>  |   |
| 17. INFORMANT <u>Son</u> Address <u>Same as Item 2.</u>  |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |   |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Prob. C.V.A. - Congestive failure</u><br>DUE TO <u>1578</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |   | (b) <u>Intestinal Obstruction</u><br>(c) <u>Prob Ca. Colon</u>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   | INTERVAL BETWEEN ONSET AND DEATH <u>1 Month</u>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                |
| 21. I certify that (I) (this hospital) attended the deceased from <u>23 March, 1967</u> , to <u>20 April, 1967</u> , that (I) (we) last saw the deceased alive on <u>4/18</u> 1967, and that death occurred at <u>11:30</u> M, from causes and on the date stated above. |   |  |   |
| 22a. SIGNATURE <u>Ann M. Dimitroff</u>   |   | 22b. DATE SIGNED <u>20 April '67</u>   |   |
| 22c. PHYSICIAN'S NAME (Type) <u>ANN M. DIMITROFF</u>   |   | 22d. ADDRESS <u>11300 Woodson Ave Kensington, Md.</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 23b. DATE THEREOF <u>4-24-67</u>  | 23c. NAME OF CEMETERY OR CREMATORY <u>North Butler Presby. Cem.</u>  | 23d. LOCATION (City or Town) (County) (State) <u>Butler, Penna.</u> |
| 24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>   |   | 25a. RECD BY REGISTRAR <u>APR 24 1967</u>  |   |





05436

## CERTIFICATE OF DEATH

05434

|  |   |  |  |
|--|---|--|--|
| 1 PLACE OF DEATH<br>a COUNTY <u>Montgomery</u> MARYLAND  |   | 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>             |  |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>  |   | c. LENGTH OF STAY IN 1b <u>3 YRS 6 mo</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens</u>   |   | e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3 NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Jane</u> Last <u>MOORE</u>  |   | 4. DATE OF DEATH Month <u>April</u> Day <u>27</u> Year <u>1967</u>   |  |
| 5 SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug. 6 1880</u>  |
| 9. AGE (In years last birthday) <u>86</u> yrs  |   | IF UNDER 1 YEAR Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Government</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>Ret'd</u>   |  |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>  |   | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |
| 13. FATHER'S NAME <u>Henry Moore</u>   |   | 14. MOTHER'S MAIDEN NAME <u>FRANCIS DASSY</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |   | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT <u>Jack W. King - Box 27 - California md.</u>  |   | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cerebral vas. disease</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arterio sclerosis</u><br>DUE TO<br>(c) |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 yrs</u><br><u>20 yrs</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                       |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1963</u> to <u>April 27 1967</u> that (I) (we) last saw the deceased alive on <u>April 27 1967</u> , and that death occurred at <u>4 PM</u> , from causes and on the date stated above.  |   |  |  |
| 22a. SIGNATURE <u>[Signature]</u>  |   | 22b. DATE SIGNED <u>4/27/67</u>  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>K. E. Kreuzburg</u>  |   | 22d ADDRESS <u>7852 16th NW Wash D.C.</u>  |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 23b DATE THEREOF <u>May 1st 1967</u>  | 23c NAME OF CEMETERY OR CREMATORY <u>Bells Methodist Cemetery</u>  | 23d LOCATION (City or Town) (County) (State) <u>Camp Springs, Maryland</u> |
| 24 FUNERAL DIRECTOR <u>Simmons Bros.</u>   |   | 25a. REC'D BY REGISTRAR <u>[Signature]</u>   |  |
| ADDRESS <u>1661-Good Hope Rd SE Wash DC</u>  |   | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>  |  |
| DATE <u>MAY 1 1967</u>   |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE

35437

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05435

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  |   |  | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>                                 |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>   |  |   |  | c. LENGTH OF STAY IN 1b <u>2 days</u>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San &amp; Hospital</u>  |  |   |  | d. STREET ADDRESS <u>9924 Woodburn Rd</u>  |  |   |  |
| 3 NAME OF DECEASED (Type or print) <u>Michael Anthony Moyer</u>   |  |   |  | 4 DATE OF DEATH <u>4 28 67</u>   |  |   |  |
| 5 SEX <u>male</u>   |  | 6 COLOR OR RACE <u>white</u>                      |  | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                     |  | 8 DATE OF BIRTH <u>2-21-45</u>  |  |
| 9 AGE (In years last birthday) <u>22</u> yrs  |  | IF UNDER 1 YEAR<br>Months <u>2</u> Days <u>28</u> |  | IF UNDER 24 HRS<br>Hours <u>9</u> Min <u>67</u>  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Heavy Machine operator</u>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Bldg. Construction</u>  |  | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u>                           |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |   |  |  |  |   |  |
| 13. FATHER'S NAME <u>Robert A. Moyer</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Mary G. Mentrup</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>  |  | 16. SOCIAL SECURITY NO. <u>219-42-3694</u>        |  | 17. INFORMANT <u>Mary G. Moyer</u>   |  | Address <u>9924 Woodburn Road Silver Spring, Maryland</u>                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Multiple skull fractures with</u><br><u>221.4</u> DUE TO<br>(b) <u>cerebral laceration and intracranial</u><br>(c) <u>hemorrhage</u><br>Condit. trans, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |   |  |  |  |   |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18).<br><u>Deceased found mortally injured beside wrecked motorcycle on Riggs Road</u> |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br><u>2:50</u> <u>4-27</u> <u>1967</u><br>Hour <u>pm</u>   |  |   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Street</u> |  |
|   |  |   |  | 20f. (City or town) <u>Hyattsville</u> (County) <u>PrGeo</u> (State) <u>Md</u>   |  |   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <u>Belden R. Reap</u>  |  |   |  | 22. DATE SIGNED <u>4/28/1967</u>   |  |   |  |
| EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>  |  |   |  | 22. DATE SIGNED <u>4/28/1967</u>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 23b. DATE THEREOF <u>May 2, 1967</u>              |  | 23c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>   |  | 23d. LOCATION (City or town) (County) (State) <u>Hyattsville, Maryland</u>          |  |
| 24. FUNERAL DIRECTOR <u>John B. Thomas</u>  |  |   |  | 25a. REC'D BY REGISTRAR <u>MAY 4 1967</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>                                     |  |
| Address <u>8434 Georgia Avenue</u>  |  |   |  |  |  |   |  |
| City <u>Silver Spring, Md.</u>  |  |   |  |  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05438

CERTIFICATE OF DEATH

05437

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>   |   | c. LENGTH OF STAY IN 1b   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bowie</u>  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Holy Cross Hospital</u>   |   | d. STREET ADDRESS<br><u>12321 Manship Lane</u>  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><u>MURPHY</u>  |   | 4. DATE OF DEATH<br>Month Day Year<br><u>APRIL 18 1967</u>  |   |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>white</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><u>APRIL 17 1967</u>  |
| 9. AGE (In years lost birthday) yrs<br><u>6</u>  |   | 10. IF UNDER 1 YEAR<br>Months Days Hours Min<br><u>6 34</u>   |   |
| 10a. U.S. LAJ OCCUPATION (Give kind of work done during most of working life, even if retired)   |   | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (County & State, or foreign country)<br><u>U.S.A.</u>                              |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |   | 13. FATHER'S NAME<br><u>Joseph Murphy</u>   |   |
| 14. MOTHER'S MAIDEN NAME<br><u>Polly Daigh</u>   |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |   |
| 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br><u>Father</u> Address  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hyaline membrane disease</u><br>DUE TO (b) <u>Prematurity</u><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this-hospital) attended the deceased from <u>4-17-</u> , 19 <u>67</u> , to <u>4-18-</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-18-</u> , 19 <u>67</u> , and that death occurred at <u>12:30 AM</u> , from causes and on the date stated above.                     |   |   |   |
| 22a. SIGNATURE<br><u>Albert J. Modlin M.D.</u>   |   | 22b. DATE SIGNED<br><u>4/20/67</u>  |   |
| 22c. PHYSICIAN'S NAME (Type) <u>Albert J. Modlin, M.D.</u>   |   | 22d. ADDRESS<br><u>704 Gorman Ave., Laurel, Md.</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>RURAL</u>  | 23b. DATE THEREOF<br><u>4/21/67</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Gate of Heaven</u>   | 23d. LOCATION (City or Town) (County) (State)<br><u>Silver Spring, Md.</u>                        |
| 24. FUNERAL DIRECTOR<br><u>Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md</u>  |   | 25a. REC'D BY REGISTRAR<br>DATE <u>APR 24 1967</u>  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |

054374



4

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
05436  
05436  
CERTIFICATE OF DEATH

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>Montgomery</i><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><i>Silver Spring</i><br>c. LENGTH OF STAY IN 1b<br><i>1 day</i><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><i>Holy Cross Hospital</i>   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><i>Maryland</i><br>b. COUNTY<br><i>Montgomery</i><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><i>Silver Spring</i><br>d. STREET ADDRESS<br><i>8712 Colesville Road</i><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><i>MARY Smythe MURPHY</i>   |                                  | 4. DATE OF DEATH<br>Month Day Year<br><i>April 4 1967</i>   |   |
| 5. SEX<br><i>female</i>  | 6. COLOR OR RACE<br><i>white</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><i>Jan 30, 1885</i> |
| 9. AGE (in years last birthday)<br><i>82</i> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   | 11. IF UNDER 24 HRS.<br>Hours Min.      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Own home</i>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><i>Ireland</i>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |   |
| 13. FATHER'S NAME<br><i>Henry Smythe</i>   |                                  | 14. MOTHER'S MAIDEN NAME<br><i>Mary Quinn</i>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><i>No</i>   |                                  | 16. SOCIAL SECURITY NO.<br><i>215-52-52537</i>  |   |
| 17. INFORMANT<br><i>Dorothy M. Vogts</i>   |                                  | Address<br><i>10714 Meadowhill Road Silver Spring, Md</i>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>RESPIRATORY ARREST</i><br><i>332X</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>CEREBRAL VASC. INSUFF.</i><br>(c) <i>RECURRING CEREBRAL THROMBOSIS</i><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><i>ASHD at onset fibrillation; Hypertension</i> |                                  |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |   |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><i>19</i>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <i>Sept 15, 1965</i> , to <i>April 4, 1967</i> , that (I) (we) last saw the deceased alive on <i>April 4</i> , 19 <i>67</i> and that death occurred at <i>6 P</i> M, from the causes and on the date stated above.   |                                  |   |   |
| 22a. SIGNATURE<br><i>Harold W. Draper</i>  |                                  | 22b. DATE SIGNED<br><i>April 4, 1967</i>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><i>HAROLD W. DRAPER M.D.</i>   |                                  | 22d. ADDRESS<br><i>411 SILVER SPRING AVE SILVER SPRING</i>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |                                  | 23b. DATE THEREOF<br><i>Apr 7, 1967</i>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><i>Parklawn Cemetery</i>   |                                  | 23d. LOCATION (City, town or county) (State)<br><i>Rockville, Maryland</i>  |   |
| 24. FUNERAL DIRECTOR<br><i>John B. Thomas</i>  |                                  | 25a. REC'D BY REGISTRAR<br><i>APR 10 1967</i>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |                                  |   |   |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

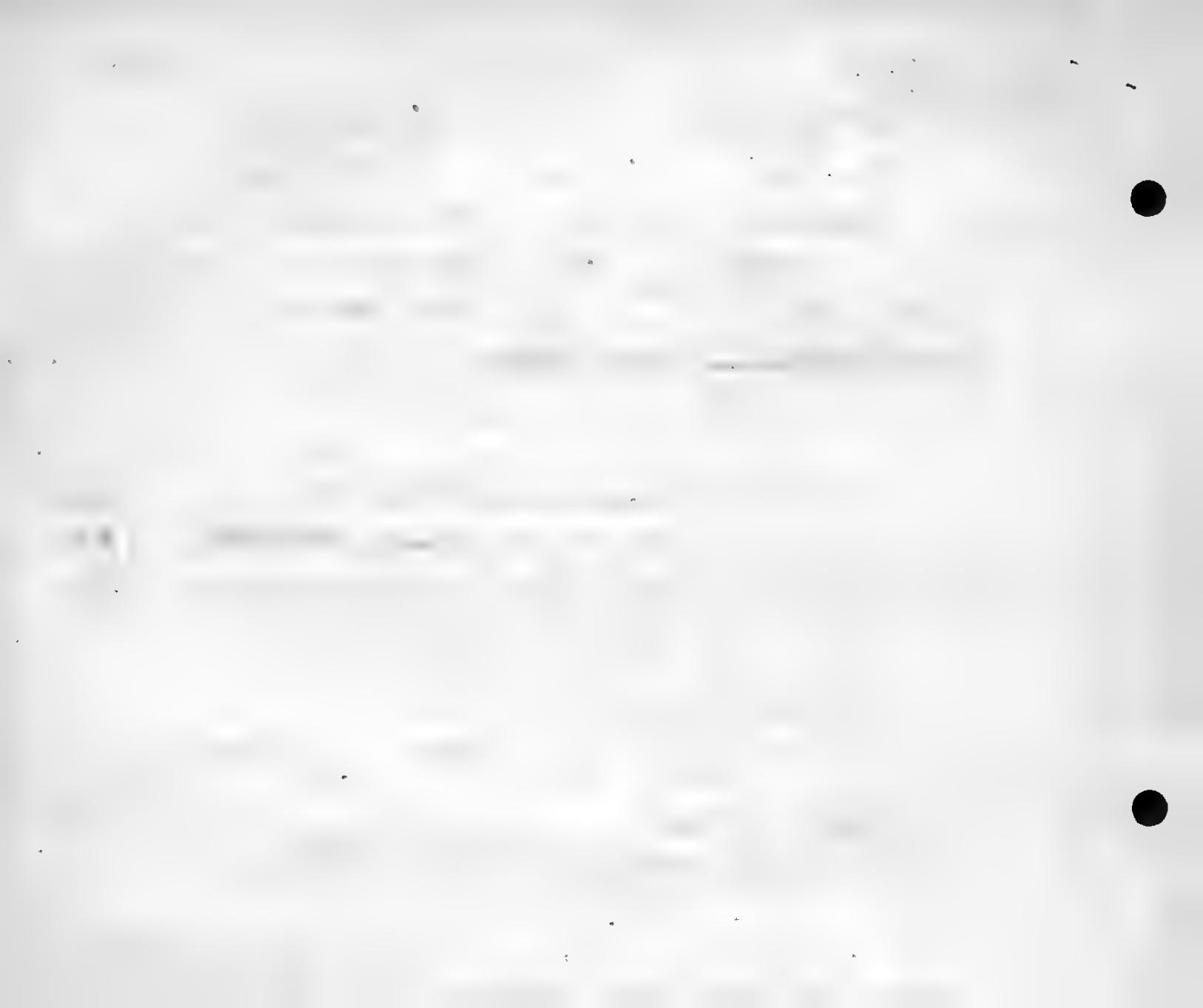
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05440

05438

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>BETHESDA</u>   | c. LENGTH OF STAY IN 1b<br><u>13 1/2 hrs.</u>  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>BETHESDA</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>SUBURBAN</u>   |  | d. STREET ADDRESS<br><u>8604 BRANDT PL.</u>   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <u>WELTY</u> Middle <u>R</u> Last <u>MURRAY</u>  |  | 4. DATE OF DEATH<br>Month <u>APRIL</u> Day <u>18</u> Year <u>1967</u>   |   |
| 5. SEX<br><u>M</u>  | 6. COLOR OR RACE<br><u>W</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>8-31-1905</u>  |
| 9. AGE (In years last birthday)<br><u>61</u> yrs  |  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>   | IF UNDER 24 HRS<br>Hours <u>  </u> Min. <u>  </u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>REAL ESTATE SALESMAN</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>FRANKS PHILIP'S</u>   | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Maryland</u>                            |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S.</u>  |  | 13. FATHER'S NAME<br><u>Reginald Murray</u>   |   |
| 14. MOTHER'S MAIDEN NAME<br><u>Charlotte Young</u>  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |   |
| 16. SOCIAL SECURITY NO.<br><u>Unknown</u>   |  | 17. INFORMANT<br>Wife<br><u>Thelma M. Murray</u>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia - Bronchial.</u><br>DUE TO (b) <u>Carcinoma of Lung. Metastatic</u><br>DUE TO (c) <u>Carcinoma of Kidney - removed.</u>               |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u><br><u>7 y.</u><br><u>7 y.</u>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>  </u> a.m. <u>  </u> p.m. <u>19</u>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1954</u> , 19 <u>  </u> , to <u>date</u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>4/17</u> 1967, and that death occurred at <u>5A</u> M, from causes and on the date stated above. |  |   |   |
| 22a. SIGNATURE<br><u>John G. Ball</u>   |  | 22b. DATE SIGNED<br><u>4/17/67</u>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>JOHN G. BALL</u>   |  | 22d. ADDRESS<br><u>7936 Old Georgetown Rd. Bethesda, Maryland</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 23b. DATE THEREOF<br><u>4-21-67</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mt. Olivet Cemetery</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>Frederick, Maryland</u>                       |
| 24. FUNERAL DIRECTOR<br><u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>   |  | 25a. REC'D BY REGISTRAR<br><u>APR 24 1967</u>   | 25b. REGISTRAR'S SIGNATURE<br><u>William J. Judge</u>   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                               |  |  |  |   |  |  |  |   |  |
|--|--|-------------------------------|--|--|--|---|--|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                               |  |  |  |   |  |  |  |   |  |
| CERTIFICATE OF DEATH   |  |                               |  |  |  |   |  |  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  |                               |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u> |  |  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>  |  |                               |  | c. LENGTH OF STAY IN 1b <u>25 days</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>                                     |  |  |  | d. STREET ADDRESS <u>6819 Red Top Road</u>                                      |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>University Nursing Home</u>  |  |                               |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |   |  |
| 3. NAME OF DECEASED (Type or print) <u>GERTRUDE B MYERS</u>  |  |                               |  |  |  | 4. DATE OF DEATH <u>APR. 18 1967</u>  |  |  |  |   |  |
| 5. SEX <u>Female</u>   |  | 6. COLOR OR RACE <u>White</u> |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>Sept 13, 1887</u>   |  | 9. AGE (In years last birthday) <u>79</u> yrs. |  | IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk - Government</u>  |  |                               |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Federal Government</u>  |  | 11. BIRTHPLACE (County & State, or foreign country) <u>York, Penna</u>  |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>                                       |  |
| 13. FATHER'S NAME <u>Clayton Myers</u>   |  |                               |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Strickhouser</u>  |  |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>  |  |                               |  | 16. SOCIAL SECURITY NO. <u>597-03-0512</u>   |  | 17. INFORMANT <u>Mr. Perry Schroeders</u> Address <u>#2 Crescent Pl. E.P.M.</u>   |  |  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Failure</u><br>DUE TO (b) <u>Cardiovascular Renal Disease</u><br>DUE TO (c) <u>1 yr.</u>   |  |                               |  |  |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>                                  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>  |  |                               |  |  |  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                               |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>  </u>   |  |   |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>  |  |                               |  | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>                          |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>  |  | 20f. (City or town) (County) (State)           |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1, 1967</u> to <u>Apr. 18, 1967</u> , that (I) <u>last</u> saw the deceased alive on <u>Apr. 18, 1967</u> , and that death occurred <u>at 2:45 PM</u> from the causes and on the date stated above. |  |                               |  |  |  |   |  |  |  |   |  |
| 22a. SIGNATURE <u>Lynwood Heiges</u>   |  |                               |  |  |  | 22b. DATE SIGNED <u>4/18/67</u>   |  |  |  |   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>LYNWOOD HEIGES, M.D., F.A.C.A.</u>   |  |                               |  |  |  | 22d. ADDRESS <u>6940 Piney Branch Road, N.W.</u>  |  |  |  |   |  |
| 23a. BURIAL/CREMATION, REMOVAL (Specify) <u>  </u>   |  |                               |  | 23b. DATE THEREOF <u>April 21-1967</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Lawrence</u>  |  |  |  | 23d. LOCATION (City, town or county) (State) <u>Washington 12, D.C.</u>         |  |
| 24. FUNERAL DIRECTOR <u>Arthur Vatter</u>  |  |                               |  | ADDRESS <u>254 Carroll St.</u>   |  | 25a. REC'D BY REGISTRAR <u>  </u>   |  | 25b. REGISTRAR'S SIGNATURE <u>  </u>           |  | DATE <u>APR 21 1967</u>   |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05442

CERTIFICATE OF DEATH

05440

|   |                                 |   |  |   |   |   |   |
|---|---------------------------------|---|--|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b> MARYLAND  |                                 |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Virginia</b><br>b. COUNTY<br><b>Fairfax</b> |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>   |                                 | c. LENGTH OF STAY IN lb<br><b>2 days</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Fairfax</b>  |   |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Naval Hospital</b>   |                                 |   |  | d. STREET ADDRESS<br><b>10570 Main Street</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>Carl Martin NAGLE</b>   |                                 |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>April 1 19 67</b>  |   |   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Cauc</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Jan. 11, 1911</b> |   | 9. AGE (In years last birthday) yrs.<br><b>56</b> | IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if ret. red)<br><b>U. S. Navy</b>   |                                 | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Belair, Pennsylvania</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>Bernard Nagle</b>   |                                 |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Carl</b>  |   |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or Unknown) (If yes give war or dates of service)<br><b>Yes 1927-1958</b>  |                                 | 16. SOCIAL SECURITY NO<br><b>225 46 4430</b>  |  | 17. INFORMANT<br><b>Fairfax</b> Address <b>Virginia</b><br><b>Mrs. Wilmoth G. Nagle, 10570 Main St.</b>   |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Alveolar cell carcinoma, lung</b><br>DUE TO<br>(b)<br>DUE TO<br>(c)   |                                 |   |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Bronchopneumonia</b>  |                                 |   |  |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACC DEW WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. 19<br>p.m.  |                                 | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>of work of work  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |   |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 30</b> , 19 <b>67</b> , to <b>April 1</b> , 19 <b>67</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 1</b> , 19 <b>67</b> , and that death occurred at <b>10:27 PM</b> from causes and on the date stated above. |                                 |   |  |   |   |   |   |
| 22a. SIGNATURE<br><i>Peter T. Kirchner</i>  |                                 |   |  | M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>                             |   | 22b. DATE SIGNED<br><b>April 3, 1967</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Peter T. Kirchner, M.D.</b>  |                                 |   |  | 22d. ADDRESS<br><b>Naval Hospital, Bethesda, Md.</b>  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                 | 23b. DATE THEREOF<br><b>4/5/67</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sunset Memorial Gardens</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Spotsylvania County, Va.</b>                  |   |
| 24. FUNERAL DIRECTOR<br><i>Randolph T. Baister</i><br><b>Elkins Funeral Home, Fredericksburg, Virginia</b>  |                                 |   |  | 25a. REC'D BY REGISTRAR<br><b>APR 4 1967</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |   |



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

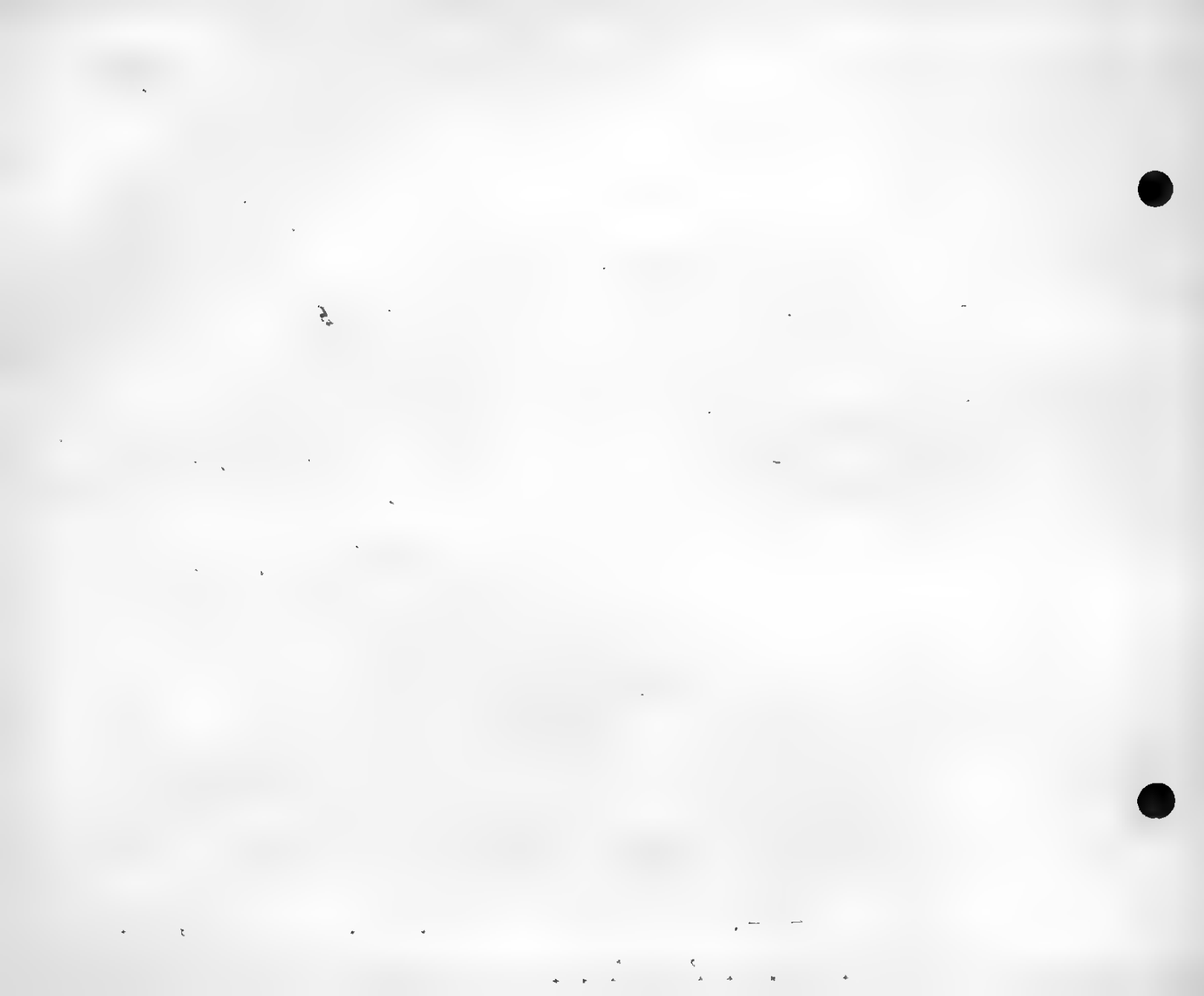
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05443

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05441

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>D.C.</u> b. COUNTY <u>✓</u>                            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Washington</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Suburban</u>  |  | d. STREET ADDRESS<br><u>4901-Cleghbrook Rd.</u>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><u>Margaret Dorby Nairn</u>   |  | 4. DATE OF DEATH<br>Month Day Year<br><u>April 22 1967</u>  |   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Oct. 22 1895</u>                           |
| 9. AGE (in years last birthday)<br><u>71</u>   |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min<br><u>19 67</u>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>None</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>Washington, D.C.</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   |
| 13. FATHER'S NAME<br><u>Rufus Hilton Dorby</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>Marie Frances Clark</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |  | 16. SOCIAL SECURITY NO<br><u>- - - - -</u>  |   |
| 17. INFORMANT<br><u>John Wilson Nairn</u>  |  | Address<br><u>15443 Dent Branch Court, Tulip Hill Md.</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Asphyxia</u><br>DUE TO (b) <u>Foreign Body Choking</u><br>stating the underlying cause (c) <u>Asphyxia due to choking</u>  |  |   |   |
| INTERVAL BETWEEN ONSET AND DEATH<br><u>5 min.</u>  |  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>None</u>  |  |   |   |
| 9. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)<br><u>Eating at Club</u>   |   |
| 20c. TIME OF INJURY Month Day Year<br>Hour <u>7:50</u> p.m. <u>4-22-67</u>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)<br><u>County Club</u>  | 20f. (City or town) (County) (State)<br><u>Bethesda Mont. Md.</u> |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |   |
| ACTUAL SIGNATURE<br><u>John S. Rogers, M.D.</u>  |  | 22. DATE SIGNED<br><u>4-23-67</u>   |   |
| EXAMINER'S NAME (Type)<br><u>John S. Rogers, M.D.</u>  |  | DEPUTY MEDICAL EXAMINER<br><u>Charles Judge</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 23b. DATE THEREOF<br><u>4-25-1967</u>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Arlington Nat'l. Cem.</u>   |  | 23d. LOCATION (City or town) (County) (State)<br><u>Arlington, Va.</u>  |   |
| 24. FUNERAL DIRECTOR<br><u>Joseph Gawler's Sons, Inc.</u>  |  | 25a. REC'D BY REGISTRAR<br><u>APR 26 1967</u>   |   |
| ADDRESS<br><u>5130 Wisc. Ave. N.W. Wash. D.C.</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician only, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

CERTIFICATE OF DEATH

05444

05442

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Montgomery  |  | MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE<br>Maryland   |  | b. COUNTY<br>P.G. Montgomery  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Silver Spring   |  | c. LENGTH OF STAY in 1b<br>7 mos. 12 days   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Silver Spring Laurel  |  | d. STREET ADDRESS<br>Fairland Road Rt. 2 B. 117   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>Fairland Nursing Home   |  |   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>Nobia   |  | First Middle Last<br>Neal   |  | 4. DATE OF DEATH<br>Month Day Year<br>April 19 19 67  |  |   |  |
| 5. SEX<br>Female  |  | 6. COLOR OR RACE<br>White   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>1/27/1876   |  |
| 9. AGE (In years last birthday)<br>91   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>-  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br>Graves Co., Ky.  |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 13. FATHER'S NAME<br>Thomas Holt Cosby  |  | 14. MOTHER'S MAIDEN NAME<br>Elizabeth Gough   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br>No  |  | 16. SOCIAL SECURITY NO.<br>220-54-0333  |  | 17. INFORMANT<br>Mr. O.T. Neal - St., Mt. Rainier, Md.  |  | Address 4104 - 31st   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4221<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) 4221<br>DUE TO<br>(c) 4221 |  | A. S.C.U.D.<br>Myocardial infarction<br>Senile  |  | (Son)   |  | INTERVAL BETWEEN ONSET AND DEATH<br>1 hr.<br>1 1/2 yr.  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>Bronchopneumonia 2/10/67 - 2/22/67  |  | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br>19  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from 1/28, 19 45 to 4/19/19 67 that (I) (we) last saw the deceased alive on 4/12 19 67 and that death occurred at 9:20 A.M. from causes and on the date stated above.  |  | 22a. SIGNATURE<br>J M Warren  |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                        |  | 22b. DATE SIGNED<br>4/19/67   |  |
| 22c. PHYSICIAN'S NAME (Type)<br>J M Warren  |  | 22d. ADDRESS<br>305 Prince Geo  |  | 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 23b. DATE THEREOF<br>4/22/67  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Fort Lincoln Com.   |  | 23d. LOCATION (City or Town) (County) (State)<br>Colmar Manor, Md.  |  | 24. FUNERAL DIRECTOR<br>Nalley's Funeral Home Inc.  |  | 25a. REC'D BY REGISTRAR<br>DATE APR 25 1967   |  |
| 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |   |  |   |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05445

CERTIFICATE OF DEATH

05443

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| 1. PLACE OF DEATH<br>a. COUNTY<br><b>MONTGOMERY</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>OLNEY, MD</b><br>c. LENGTH OF STAY IN 1b<br><b>GAITH ERSB URG</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>MONTGOMERY GENERAL</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE<br><b>MD</b><br>b. COUNTY<br><b>MONTGOMERY</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>GAITH ERSB URG</b><br>d. STREET ADDRESS<br><b>RT 1 Box 196</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>BESSIE GAVR NEHOUSE</b>   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>APRIL 16 19 67</b>  |  |
| 5. SEX<br><b>F</b>   | 6. COLOR OR RACE<br><b>WHITE</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>2-9-89</b>  |
| 9. AGE (In years last birthday)<br><b>78 yrs</b>   |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min<br><b>16 19 67</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Frederick Co., Md.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>WILLIAM BURDETTE</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>SALLY HILTON</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO   |  |
| 17. INFORMANT<br><b>Hilton B. Nehouse, Item 2</b>  |  | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br>DUE TO<br>(b) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO<br>(c) <b>gro.</b><br>Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br><b>4x01</b> |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Diabetes mellitus, bronchi pneumonia</b>  |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)   | 20f. (City or town) (County) (State)                                     |
| 21. I certify that (I) (this hospital) attended the deceased from <b>4-3-67</b> , 19 <b>67</b> , to <b>4-16</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>4-15</b> , 19 <b>67</b> , and that death occurred at <b>5 AM</b> , from causes and on the date stated above   |  |  |  |
| 22a. SIGNATURE<br><b>Frederick Moomau</b> M.D.   |  | 22b. DATE SIGNED<br><b>4-16-67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Frederick Moomau, M.D.</b>  |  | 22d. ADDRESS<br><b>Medical Center, Sandy Spring, Md.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>April 19, 1967</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Salem Meth.</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Cedar Grove, Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>Olin L. Molesworth, Damascus, Md.</b>   |  | 25a. REC'D BY REGISTRAR<br><b>APR 20 1967</b>  |  |
|  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |



CERTIFICATE OF DEATH

05446

05446

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Reside (to nearest address))<br>a. STATE <u>MD</u> b. COUNTY <u>PG</u>                         |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Takoma Park</u>  |  | c. LENGTH OF STAY IN 1b<br><u>10 DAYS</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>WASH SAN + HOSP</u>  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br><u>NOBLE CORNELIUS NORFOLK</u>   |  | 4. DATE OF DEATH<br>Month <u>4</u> Day <u>1</u> Year <u>1967</u>   |   |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>W</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><u>April 19, 1912</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Heavy Equipment Oper. State Roads</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>MD</u>   |   |
| 11. BIRTHPLACE (County & State or foreign country)<br><u>MD</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |   |
| 13. FATHER'S NAME<br><u>UNKNOWN</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>UNKNOWN</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |  | 16. SOCIAL SECURITY NO   |   |
| 17. INFORMANT<br><u>Larry Norfolk</u> Md.<br><u>130 Park Rd. Riviera Beach</u>  |  | Address  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)<br><u>1621</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Bacterial infection &amp; destruction lung</u><br>(c) <u>Bronchogenic carcinoma</u> |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>Months</u><br><u>years</u>  |   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Pulmonary emphysema; Sarcoidosis</u>   |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>3/27</u> , 19 <u>67</u> , to <u>4/1</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>4/1</u> , 19 <u>67</u> and that death occurred at <u>7:30</u> P.M. from causes and on the date stated above.  |  |  |   |
| 22a. SIGNATURE<br><u>Kenneth Cruze</u> MD   |  | 22b. DATE SIGNED<br><u>4-3-67</u>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Kenneth Cruze</u>  |  | 22d. ADDRESS<br><u>831 University Blvd E. Md.</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL, ETC.   | 23b. DATE THEREOF<br><u>4-5-67</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Washington National</u>   | 23d. LOCATION (City or Town) (County) (State)<br><u>Suitland, Md. Pr. Geo. Co</u> |
| 24. FUNERAL DIRECTOR<br><u>Ritchie Bros. Funeral Home Maryland</u>  |  | 25a. REC'D BY REGISTRAR<br><u>APR 4 1967</u>   |   |
|   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05445

05447

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Takoma Park</b><br>c. LENGTH OF STAY IN 1b<br><b>4 days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Washington Sanitarium and Hospital</b> |                                  | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Montgomery</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b><br>d. STREET ADDRESS<br><b>9420 Columbia Blvd.</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3 NAME OF DECEASED<br>(Type or print)<br><b>Effie Mae Norman</b>  |                                  | 4 DATE OF DEATH<br>Month <b>April</b> Day <b>15</b> Year <b>1967</b>  |   |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b> | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8 DATE OF BIRTH<br><b>9-24-87</b>                                 |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>  |                                  | 9b. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>  | 9 AGE (In years last birthday)<br><b>79</b> yrs.                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>   | 11 BIRTHPLACE (County & State, or foreign country)<br><b>Ohio</b> |
| 12 CITIZEN OF WHAT COUNTRY?<br><b>America</b>   |                                  | 13 FATHER'S NAME<br><b>Thomas Gunn</b>  |   |
| 14 MOTHER'S MAIDEN NAME<br><b>Eunice Nichols</b>  |                                  | 15 WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>  |   |
| 16 SOCIAL SECURITY NO<br><b>578-50-9432A</b>  |                                  | 17 INFORMANT<br><b>Patient's chart</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>acute Cardiac Arrest</b><br>DUE TO (b) <b>myocarditis</b><br>DUE TO (c) <b>arteriosclerotic heart disease</b>   |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 years ±</b><br><b>10 years ±</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Hypertension (systolic B.P. varied 160 to 260)</b>   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>no</b>   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II, of item 18)<br><b>no injury - spontaneous rupture of coronary blood vessel 4-13-67</b>  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>—</b> p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   |
| 20e. PAGE OF INJURY (Home, farm, factory, street, office bldg, etc.)<br><b>—</b>  |                                  | 20f. (City or town) (County) (State)<br><b>—</b>  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>4-11-</b> , 19 <b>67</b> , to <b>4-15</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>4-14-1967</b> , and that death occurred at <b>1:15 AM</b> , from causes and on the date stated above.   |                                  |   |   |
| 22a. SIGNATURE<br><b>Read N. Calvert M.D.</b>   |                                  | 22b. DATE SIGNED<br><b>4-15-67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>READ N. CALVERT</b>  |                                  | 22d. ADDRESS<br><b>909 Pershing Drive Silver Spring</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal - Burial</b>  |                                  | 23b. DATE THEREOF<br><b>APRIL 17, 1967</b>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenlawn Cem -</b>  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Columbus OHIO</b>   |   |
| 24. FUNERAL DIRECTOR<br><b>Joseph Gawlers</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>Charles Judge</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |                                  | DATE<br><b>APR 24 1967</b>  |   |

MEDICAL CERTIFICATION





05448

CERTIFICATE OF DEATH

05446

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |                           |  |  |
|--|---------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                           | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |                           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>  |  |
| c. LENGTH OF STAY IN 1b <u>DOA</u>   |                           | d. STREET ADDRESS <u>3945 Newdale Rd</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>   |                           | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) <u>Oliver Belle Novak</u>  |                           | 4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1967</u>   |  |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 13 1891</u> 75 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |                           | 11. BIRTHPLACE (County & State, or foreign country) <u>Clayton Georgia</u>   |  |
| 10b. KIND OF BUSINESS OR INDUSTRY  |                           | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |
| 13. FATHER'S NAME <u>Augustus Swafford</u>   |                           | 14. MOTHER'S MAIDEN NAME <u>Ella Duncan</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>  |                           | 16. SOCIAL SECURITY NO. <u>272-10-07753</u>  |  |
| 17. INFORMANT <u>Husband</u> Address <u>Same as Item 2.</u>  |                           | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>DUE TO (b) <u>Arteriosclerotic Heart Disease</u><br>DUE TO (c) <u>10 years</u>   |                           | INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Distilled Measles</u>  |                           |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                           | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)       |  |
| 20b. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>  |                           | 20c. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work   |  |
| 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                           | 20e. (City or town) (County) (State)   |  |
| 21. I certify that (I) (the hospital) attended the deceased from <u>November, 1958</u> to <u>4/19, 1967</u> , that (I) (we) lost saw the deceased alive on <u>4/16, 1967</u> , and that death occurred at <u>10:52 AM</u> , from causes on and on the date stated above. |                           |  |  |
| 22a. SIGNATURE <u>J. Blaine Fitzgerald</u> M.D.  |                           | 22b. DATE SIGNED <u>4/19/67</u>  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>J. BLAINE FITZGERALD</u>   |                           | 22d. ADDRESS <u>8218 Wisconsin Ave. Bethesda, Maryland</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                           | 23b. DATE THEREOF <u>4-22-67</u>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <u>George Wash. Cemetery</u>  |                           | 23d. LOCATION (City or town) (County) (State) <u>Hyattsville, Maryland</u>   |  |
| 24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>   |                           | 25a. REC'D BY REGISTRAR <u>APR 24 1967</u>   |  |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |                           |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

| <div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b><br/> <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b><br/> <b>CERTIFICATE OF DEATH</b> </div>  |  |  |   |  |  |   |  |   |                                  |  |  |
|--|--|--|---|--|--|---|--|---|----------------------------------|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>MONTGOMERY</u> MARYLAND<br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u><br>c. LENGTH OF STAY IN 1b <u>18 DAYS</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>FAIRLAND NURSING HOME</u>   |  |  |   |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MD.</u> b. COUNTY <u>1</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u><br>d. STREET ADDRESS <u>10600 MONTROSE AVE</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |                                  |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print) <u>GLADYS F. O'DONNELL</u>  |  |  | <b>4. DATE OF DEATH</b> Month <u>4</u> - Day <u>13</u> Year <u>1967</u> |  |  | <b>5. SEX</b> <u>F</u>  |  |   | <b>6. COLOR OR RACE</b> <u>W</u> |  |  |
| <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  | <b>8. DATE OF BIRTH</b> <u>8/8/99</u>                                   |  |  | <b>9. AGE</b> (in years last birthday) <u>67</u> yrs. <div>             IF UNDER 1 YEAR: Months <u>67</u> Days <u>67</u> </div> IF UNDER 24 HRS. Hours <u>67</u> Min. <u>67</u>   |  |   |                                  |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>R.N.</u>   |  |  |   | <b>10b. KIND OF BUSINESS OR INDUSTRY</b>   |  |   |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>WASH. D.C.</u>  |                                  |  |  |
| <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>  |  |  |   |  |  | <b>13. FATHER'S NAME</b> <u>FRANK FEILDS</u>  |  |   |                                  |  |  |
| <b>14. MOTHER'S MAIDEN NAME</b> <u>MARGARET JACOBS</u>   |  |  |   |  |  | <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>  |  |   |                                  |  |  |
| <b>16. SOCIAL SECURITY NO.</b> <u>214-32-9536-A</u>  |  |  |   |  |  | <b>17. INFORMANT</b> <u>Daughter</u> Address <u>Same as Item 2.</u>   |  |   |                                  |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u><br>(b) <u>Hypertensive Cardiovascular Disease</u><br>(c) <u>Myocardial Infarction</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Urinary Tract Infection</u> |  |  |   |  |  |   |  |   |                                  |  |  |
| <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |   |  |  |   |  |   |                                  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>   |  |  |   |  |  |   |  |   |                                  |  |  |
| <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |  |  |   |  |   |                                  |  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour <u>a.m.</u> p.m. <u>19</u>   |  |  |   | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |   |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) |                                  |  |  |
| <b>20f. (City or town)</b> (County) (State)  |  |  |   | <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>March 30, 1967</u> <b>to</b> <u>April 13, 1967</u> <b>that (I) (we) last saw the deceased alive on</b> <u>April 9, 1967</u> <b>and that death occurred at</b> <u>11:00 P.M.</u> <b>from the causes and on the date stated above.</b> |  |   |  |   |                                  |  |  |
| <b>22a. SIGNATURE</b> <u>Boris Rabkin</u>  |  |  |   |  |  | <b>22b. DATE SIGNED</b> <u>April 13, 1967</u>   |  |   |                                  |  |  |
| <b>22c. PHYSICIAN'S NAME (Type)</b> <u>Boris Rabkin</u>  |  |  |   |  |  | <b>22d. ADDRESS</b> <u>Silver Spring, Md.</u><br><u>1019 University Boulevard East</u>  |  |   |                                  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>   |  |  |   | <b>23b. DATE THEREOF</b> <u>4-18-67</u>  |  |   |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington Natl Cem.</u>          |                                  |  |  |
| <b>23d. LOCATION (City, town or county)</b> (State) <u>Arlington, Virginia</u>   |  |  |   | <b>24. FUNERAL DIRECTOR</b> <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>  |  |   |  | <b>25a. REC'D BY REGISTRAR</b> <u>APR 17 1967</u>                             |                                  |  |  |
| <b>25b. REGISTRAR'S SIGNATURE</b> <u>J. Charles Judge</u>  |  |  |   |  |  |   |  |   |                                  |  |  |



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05450

## CERTIFICATE OF DEATH

05448

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |                           |  |                                     |   |  |  |  |
|---|---------------------------|--|-------------------------------------|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                           |  |                                     | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  |                           | c. LENGTH OF STAY IN 'b' <u>5 days</u>   |                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>  |                           |  |                                     | d. STREET ADDRESS <u>6006 Broadbranch Road</u>  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) <u>Grace R. Antreich</u>  |                           |  |                                     | 4. DATE OF DEATH Month <u>4</u> Day <u>10</u> Year <u>1967</u>  |  |  |  |
| 5. SEX <u>F.</u>  | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct 15 1887</u> | 9. AGE (In years last birthday) <u>79</u> yrs.  | 10. IF UNDER 1 YEAR Months <u>0</u> Days <u>19</u> |  | 11. IF UNDER 24 HRS. Hours <u>17</u> Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Educator</u>  |                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>AGE</u>   |                                     | 11. BIRTHPLACE (County & State, or foreign country) <u>Brooklyn N.Y.</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |
| 13. FATHER'S NAME <u>Louis W. Bailey</u>  |                           |  |                                     | 14. MOTHER'S MAIDEN NAME <u>Rose Clare Mapes</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)   |                           | 16. SOCIAL SECURITY NO. <u>579-48-99</u>   |                                     | 17. INFORMANT <u>William R. Kessel</u>  |  | Address <u>5410 Connecticut Ave. Wash. D.C.</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>DUE TO (b) <u>Chronic congestive heart failure</u><br>DUE TO (c) <u>Myocarditis + valvular heart disease</u>                                |                           |  |                                     |   |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                           |  |                                     |   |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           |  |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.   |                           | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work   |                                     | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>67</u> , to <u>10 Apr</u> , 19 <u>67</u> , that (I) (was) last saw the deceased alive on <u>10 Apr</u> , 19 <u>67</u> , and that death occurred at <u>10:30 PM</u> , from causes and on the date stated above. |                           |  |                                     |   |  |  |  |
| 22a. SIGNATURE <u>Herbert Martyn Jr</u>   |                           |  |                                     | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>      |  | 22b. DATE SIGNED <u>10 Apr 67</u>  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>HERBERT MARTYN JR</u>   |                           |  |                                     | 22d. ADDRESS <u>4740 Cherry Chase Dr. Ch. Ch. Md</u>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                           | 23b. DATE THEREOF <u>4/14/67</u>   |                                     | 23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>   |  | 23d. LOCATION (City or town) (County) (State) <u>Baltimore Md</u>                              |  |
| 24. FUNERAL DIRECTOR <u>Jas. T. Ryan, Inc.</u>  |                           |  |                                     | 25a. REC'D BY REGISTRAR <u>J. Ryan, Jr.</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>J. Ryan, Jr.</u>   |  |



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

05451

05449

|   |  |  |  |
|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u> MARYLAND<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u><br>c. LENGTH OF STAY IN lb<br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethesda Nursing Home</u>  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u><br>d. STREET ADDRESS <u>8201 16th st.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| <b>3. NAME OF DECEASED</b> (Type or print) <u>Samuel A OSTRROW</u><br>First Middle Last<br><b>5. SEX</b> <u>M</u> <b>6. COLOR OR RACE</b> <u>W</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/><br><b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Purchasing</u><br><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Construction</u><br><b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Bridgeport, Conn.</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u> |  | <b>4. DATE OF DEATH</b> <u>APRIL 12 1967</u><br>Month Day Year<br><b>8. DATE OF BIRTH</b> <u>11/30/95</u><br><b>9. AGE</b> (In years last birthday) <u>71</u> yrs<br>IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min   |  |
| <b>13. FATHER'S NAME</b> <u>Abraham G. Ostrow</u><br><b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)<br><b>16. SOCIAL SECURITY NO</b> <u>554-16-8607</u><br><b>17. INFORMANT</b> <u>Allan M. Ostrow (son)</u> Address  |  | <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARCINOMA OF lung &amp; Generalized Metastases</u><br>DUE TO (b) _____<br>DUE TO (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b><br><b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)<br><b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. _____ p.m. _____ 19____   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)<br><b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work<br><b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><b>20f. (City or town) (County) (State)</b>  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from <u>OCTOBER 1966</u> to <u>APRIL 12, 1967</u>, that (I) (we) last saw the deceased alive on <u>4/11/67</u>, and that death occurred at <u>4:30 A.M.</u> from causes and on the date stated above.</b>   |  |  |  |
| <b>22a. SIGNATURE</b> <u>William S. Miller M.D.</u><br><b>22c. PHYSICIAN'S NAME (Type)</b> <u>William S. Miller M.D.</u>  |  | <b>22b. DATE SIGNED</b> <u>4/12/67</u><br><b>22d. ADDRESS</b> <u>4201-Conn. Ave. N.W. D.C.</u>   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Cremation</u><br><b>23b. DATE THEREOF</b> <u>4/12/67</u><br><b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Lee's Crematorium</u><br><b>23d. LOCATION (City or Town) (County) (State)</b> <u>Washington, D. C.</u>   |  | <b>24. FUNERAL DIRECTOR</b> <u>Lee Funeral Home</u> ADDRESS <u>Washington, D.C.</u><br><b>25a. REC'D BY REGISTRAR</b> <u>APR 14 1967</u><br><b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

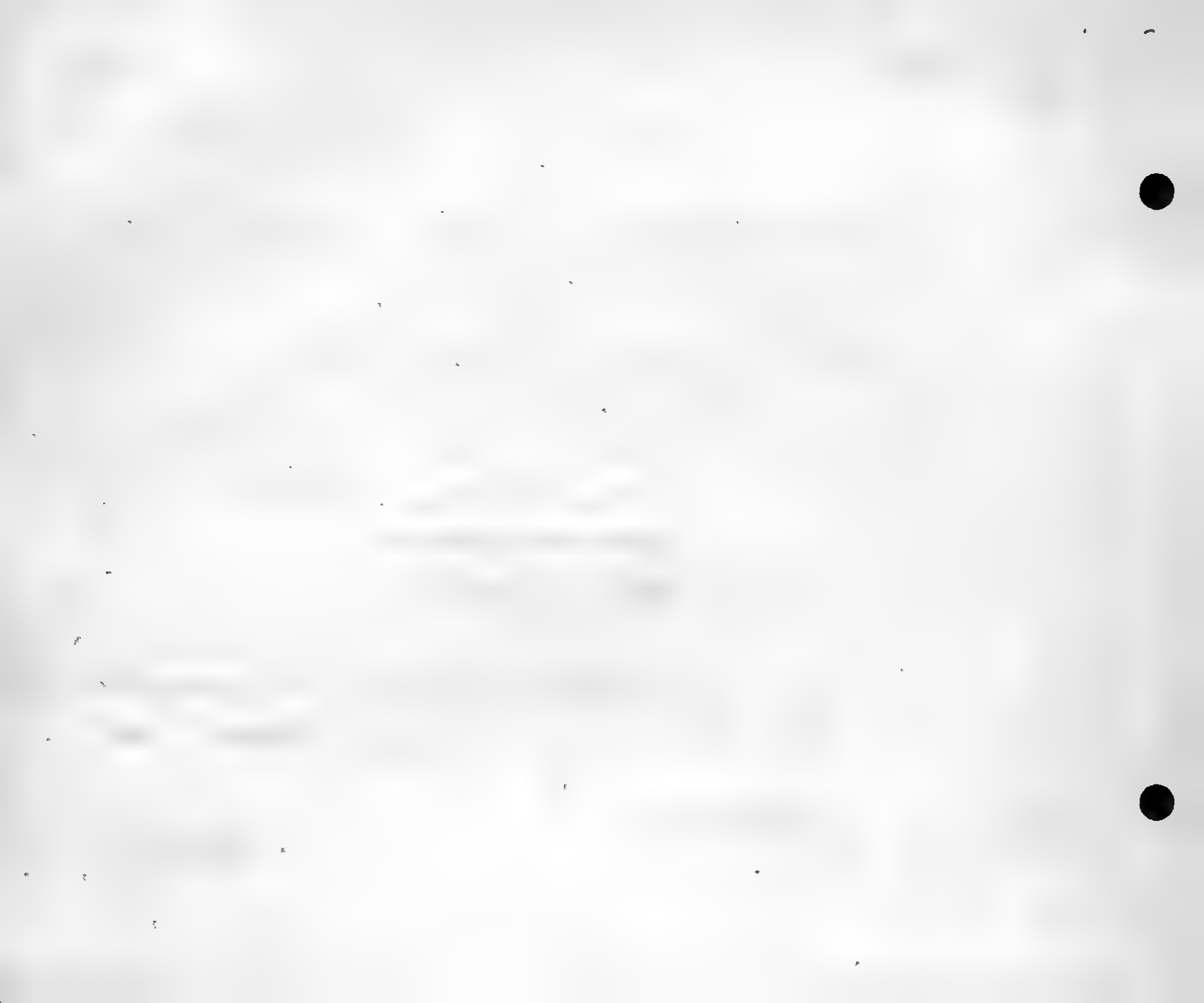
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05452

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05450

|  |                                  |   |                                    |  |  |   |   |
|--|----------------------------------|---|------------------------------------|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                                  |   |                                    | 2. USUAL RESIDENCE (Where deceased lived, if institut on; Residence before admission)<br>a. STATE <u>md.</u> b. COUNTY <u>Mont. Co.</u>  |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>  |                                  | c. LENGTH OF STAY IN It<br><u>3 hrs.</u>  |                                    | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>  |  |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Suburban</u>  |                                  |   |                                    | d. STREET ADDRESS<br><u>5504-Charlotte Rd</u>  |  | 15. RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print) <u>Virginia Thorpe</u>  |                                  |   |                                    | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>17</u> Year <u>1967</u>  |  |   |   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>2/27/14</u> | 9. AGE (In years last birthday)<br><u>53</u> yrs   | IF UNDER 1 YEAR<br>Months <u>0</u> Days <u>0</u> |   | IF UNDER 24 HRS.<br>Hours <u>0</u> Min <u>0</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>real estate</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Patronage</u>   |                                    | 11. BIRTHPLACE (State or foreign country)<br><u>Kentucky</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>   |   |
| 13. FATHER'S NAME<br><u>William Thorpe</u>   |                                  |   |                                    | 14. MOTHER'S MAIDEN NAME<br><u>Eva. (Ginger) (Gough)</u>   |  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes no, or unknown) <u>no</u>  |                                  | 16. SOCIAL SECURITY NO<br><u>400-24-8733</u>  |                                    | 17. INFORMANT<br><u>Tanice Keys</u>  |  |   |   |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardiac Tamponade - Massive -</u><br>DUE TO <u>Rupture of Heart -</u><br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost <u>Auto Accident.</u><br>DUE TO <u>3 hr.</u><br><u>3 hr.</u>   |                                  |   |                                    |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 hr.</u>  |   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |                                    |  |  |   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |                                  |   |                                    | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)<br><u>Driving car on left side of road crashed into oncoming car</u>   |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br><u>5:55 pm 4/17 1967</u>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work  |                                    | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>Street.</u>   |  | 20f. (City or town) (County) (State)<br><u>Bethesda - Mont. Md.</u>                             |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                  |   |                                    |  |  |   |   |
| ACTUAL SIGNATURE<br><u>John G. Ball</u><br>EXAMINER'S NAME (Type)<br>JOHN G. BALL  |                                  |   |                                    | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>4/18/67</u><br>Address (Street city town, or county) <u>Bethesda, Md.</u> |  |   |   |
| 23a. BURIAL CREMATION REMOVAL (Specify)<br><u>Burial</u>   |                                  | 23b. DATE THEREOF<br><u>4-20-67</u>   |                                    | 23c. NAME OF CEMETERY OR CREMATORY<br><u>St. Paul's Cemetery</u>   |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Laytonsville, Maryland</u>                  |   |
| 24. FUNERAL DIRECTOR<br><u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>  |                                  |   |                                    | 25a. REC'D BY REG STRAR<br><u>APR 24 1967</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any death, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05453

CERTIFICATE OF DEATH

05451

|  |                               |  |  |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>                  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Takehome Park, Md.</u>  |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>   |  |
| c. LENGTH OF STAY IN 1b  |                               | d. STREET ADDRESS<br><u>212 Hanner Drive</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Washington Sanitarium &amp; Hosp</u>  |                               | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><u>Josephine</u> First <u>None</u> Middle <u>Pappalardo</u> Last   |                               | 4. DATE OF DEATH<br>Month <u>4</u> Day <u>26</u> Year <u>1967</u>  |  |
| 5. SEX<br><u>F</u>   | 6. COLOR OR RACE<br><u>W.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><u>March 9, 1877</u> |
| 9. AGE (In years last birthday) yrs.<br><u>90</u>  |                               | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>TAILOR-RETIRED</u>  |  |
| 10b. KIND OF BUSINESS OR INDUSTRY<br><u>TAILORING</u>  |                               | 11. BIRTHPLACE (County & State, or foreign country)<br><u>ITALY</u>  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>American</u>  |                               | 13. FATHER'S NAME<br><u>Antonio Bonanno</u>  |  |
| 14. MOTHER'S MAIDEN NAME<br><u>Vera Barzi</u>  |                               | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>NO</u>  |  |
| 16. SOCIAL SECURITY NO<br><u>579-14-1703</u>   |                               | 17. INFORMANT<br><u>Mrs. Santina Miller, (same as #2.)</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u><br>DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO (c) <u></u>                           |                               | INTERVAL BETWEEN ONSET AND DEATH<br><u>8 hrs</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                               | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>o.m.</u> <u>19</u> p.m.  |                               | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan 2, 1967</u> , to <u>April 26, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 26, 1967</u> , and that death occurred at <u>5:18 p.m.</u> from causes and on the date stated above. |                               |  |  |
| 22a. SIGNATURE<br><u>Raymond Bradshaw, Jr.</u> M.D.  |                               | 22b. DATE SIGNED<br><u>April 26, 1967</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>RAYMOND BRADSHAW, JR.</u>   |                               | 22d. ADDRESS<br><u>345 University Blvd, W. Silver Spring</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                               | 23b. DATE THEREOF<br><u>May 1, 1967</u>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Fort Lincoln Cemetery</u>   |                               | 23d. LOCATION (City or Town) (County) (State)<br><u>Prince Geo. Co. Maryland</u>   |  |
| 24. FUNERAL DIRECTOR<br><u>Arthur Walters</u>  |                               | 25a. REC'D BY REGISTRAR<br><u>Charles Judge</u>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |                               | DATE<br><u>MAY 1 1967</u>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05454

CERTIFICATE OF DEATH

05452

|   |                                  |   |   |  |   |   |   |
|---|----------------------------------|---|---|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>Virginia</u> b. COUNTY <u>Amherst</u> |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>   |                                  | c. LENGTH OF STAY IN 1b<br><u>3 days</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Amherst</u>   |   |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>The Clinical Center, Bethesda, Md. 20014</u>   |                                  |   |   | d. STREET ADDRESS<br><u>Box 178</u>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><u>James Edward Pendleton</u>   |                                  |   |   | 4. DATE OF DEATH<br>Month Day Year<br><u>April 30 19 67</u>  |   |   |   |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>February 7, 1917</u> |  | 9. AGE (In years last birthday)<br><u>50</u> yrs. | IF UNDER 1 YEAR<br>Months Days Hours Min.<br>IF UNDER 24 HRS.                                     |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Pantry worker</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>College</u>   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Virginia</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   |
| 13. FATHER'S NAME<br><u>James L. Pendleton</u>  |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Mary E. Gilmore</u>   |   |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>Yes 1943-1945</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>203-20-0703</u>   |   | 17. INFORMANT <u>The Medical Record</u> Address<br><u>The Clinical Center, Bethesda, Md. 20014</u>   |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cor pulmonale, Respiratory Failure</u><br><u>2041</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }<br>(b) <u>Generalized Bronchospasm</u><br>DUE TO<br>(c) <u>Chronic Myelogenous Leukemia in Blastic Crisis</u> |                                  |   |   |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 Hrs.</u><br><u>4 Days</u><br><u>1 1/2 Yrs.</u><br><u>1 Wk.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>(1) Renal Failure, (2) Gastrointestinal Hemorrhage.</u>   |                                  |   |   |  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)  |   | 20f. (City or town) (County) (State)  |   |
| 21. I certify that <del>XX</del> (this hospital) attended the deceased from <u>April 27</u> , 19 <u>67</u> , to <u>April 30</u> , 19 <u>67</u> that <del>XX</del> (we) lost saw the deceased alive on <u>April 30</u> 19 <u>67</u> , and that death occurred at <u>6:25</u> M, from causes and on the date stated above.  |                                  |   |   |  |   |   |   |
| 22a. SIGNATURE<br><u>I. David Goldman</u> M.D.  |                                  |   |   | ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>              |   | 22b. DATE SIGNED<br><u>May 1, 1967</u>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>I. David Goldman, M. D.</u>  |                                  |   |   | 22d. ADDRESS<br><u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u>   |                                  | 23b. DATE THEREOF<br><u>5/1/67</u>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Rockville, Md</u>   |   | 23d. LOCATION (City or town) (County) (State)<br><u>Amherst, Va.</u>                              |   |
| 24. FUNERAL DIRECTOR<br><u>Robert L. Snowden</u>  |                                  |   |   | ADDRESS<br><u>Rockville, Md</u>  |   | 25a. REC'D BY REGISTRAR<br><u>MAY 5 1967</u>  |   |
|   |                                  |   |   |  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   |



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only every, within 72 hours after death.

VR A15 (4)  
20 M 1/66

**MARYLAND STATE DEPARTMENT OF HEALTH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G3-3-11/67 p2

# CERTIFICATE OF DEATH

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>ROCKVILLE</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington, D.C.</b>                                   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>POTOMAC VALLEY NURSING HOME</b><br><b>1235 POTOMAC VALLEY RD.</b>   |  | d. STREET ADDRESS<br><b>431 Oneida Pl. N.W.</b>   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 3. NAME OF DECEASED (Type or print) <b>VERNON</b>  |  | 4. DATE OF DEATH <b>4/24</b> <b>1967</b>  |  |
| 5. SEX <b>M</b>  |  | 6. COLOR OR RACE <b>C</b>   |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>   |  | 8. DATE OF BIRTH <b>7-4-15</b>  |  |
| 9. AGE (In years last birthday) <b>52</b> yrs  |  | 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS Hours Min   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Post. Employee</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>South Carolina</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   |  |
| 13. FATHER'S NAME<br><b>Daniel Peoples</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Charles</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><b>yes WWII</b>  |  | 16. SOCIAL SECURITY NO  |  |
| 17. INFORMANT <b>Pauline White</b> <b>431 Oneida Pl. N.W.</b>  |  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cervicovascularoma, Brain Metastasis</b><br>1930<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>(c) |  | INTERVA. BETWEEN ONSET AND DEATH<br><b>10 days</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>3/14/67</b> , 19__ to <b>4/23/67</b> , 19__, that (I) (we) last saw the deceased alive on <b>4/23/67</b> , 19__, and that death occurred at <b>3:15 A.M.</b> from causes and on the date stated above                           |  |   |  |
| 22a. SIGNATURE<br><b>Henry C. Scruggs, MD.</b>   |  | 22b. DATE SIGNED<br><b>4/24/67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Henry C. Scruggs, MD.</b>  |  | 22d. ADDRESS  |  |
| 23a. BURIAL CREMATION, REMOVAL (Specify) <b>4/29/67</b>  |  | 23b. DATE THEREOF   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Harmony Memorial</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Landover, Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Fraser 9.61</b>   |  | 25a. REC'D BY REGISTRAR<br><b>APR 27 1967</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Michaela Judge</b>  |  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared by Dr. Hoag

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |  |  |  |  |   |  |  |  |
|--|--|---|--|--|--|--|--|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |   |  |  |  |  |  |   |  |  |  |
| CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |   |  |  |  |
| 05456  |  |   |  |  |  |  |  |   |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND  |  |   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u> |  |   |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>SILVER SPRING Md.</u>   |  |   |  | c. LENGTH OF STAY IN 1b  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bladensburg</u>   |  |   |  | d. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Holy Cross Hospital</u>   |  |   |  |  |  | d. STREET ADDRESS<br><u>5442 Tilden Road</u>   |  |   |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)   |  | First <u>VICKY</u>  |  | Middle <u>C</u>  |  | Last <u>PETTIT</u>   |  | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>21</u> Year <u>1967</u> |  |  |  |
| 5. SEX<br><u>F</u>   |  | 6. COLOR OR RACE<br><u>W</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>12/2/58</u>   |  | 9. AGE (In years last birthday)<br><u>8</u> yrs.                      |  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>      |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>minor</u>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Virginia (Page Co.)</u>  |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  |
| 13. FATHER'S NAME<br><u>John A. Pettit</u>   |  |   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><u>Barbara McCleary</u>  |  |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><u>no</u>   |  |   |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><u>John A. Pettit</u>   |  | Address<br><u>(Item 2)</u>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Increased intracranial pressure</u><br><u>1966</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pontine glioma</u><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |   |  |  |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>6 weeks</u><br><u>18 wks.</u>                   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |   |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June 1, 1966</u> to <u>April 11, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 19, 1967</u> , and that death occurred at <u>8:25 AM</u> , from the causes and on the date stated above.  |  |   |  |  |  |  |  |   |  |  |  |
| 22a. SIGNATURE<br><u>John Thomas Hoag M.D.</u>   |  |   |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                  |  | 22b. DATE SIGNED<br><u>April 11, 1967</u>                             |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>John Thomas Hoag</u>  |  |   |  |  |  | 22d. ADDRESS<br><u>1015 Spring St., Silver Spring, Md.</u>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 23b. DATE THEREOF<br><u>Apr. 13, '67</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Graves Chapel</u>   |  | 23d. LOCATION (City, town or county) (State)<br><u>Stanley Virginia</u>  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><u>John A. Pettit</u>  |  |   |  |  |  | ADDRESS<br><u>  </u>   |  | 25a. REC'D BY REGISTRAR<br><u>Charles Judge</u>                       |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                                     |  |
| DATE <u>APR 14 1967</u>  |  |   |  |  |  |  |  |   |  |  |  |



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

35457

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05455

|   |                                 |   |  |   |  |
|---|---------------------------------|---|--|---|--|
| 1. PLACE OF DEATH<br>a COUNTY <b>Montgomery</b> MARYLAND  |                                 |   | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a STATE <b>Maryland</b> b COUNTY <b>Howard</b> |   |  |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Olney</b>   |                                 | c LENGTH OF STAY IN 1b<br><b>2 1/2 hrs.</b>   |  | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Ellicott City</b> |  |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Montgomery General Hospital</b>   |                                 |   | d STREET ADDRESS<br><b>42 Evergreen Ave.</b>   |   | e IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Richard</b> Middle <b>Lawrence</b> Last <b>Phelps</b>   |                                 |   | 4. DATE OF DEATH<br>Month <b>4</b> Day <b>14</b> Year <b>67</b>  |   |  |
| 5 SEX<br><b>Male</b>  | 6 COLOR OR RACE<br><b>White</b> | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8 DATE OF BIRTH<br><b>8-1-49</b>   | 9 AGE (In years last birthday) yrs <b>19</b>  | IF UNDER 1 YEAR<br>Months <b>14</b> Days <b>6</b>  |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Student</b>  |                                 | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>High School</b>   |  | 11 BIRTHPLACE (State or foreign country)<br><b>London, England</b>                                      |  |
| 13. FATHER'S NAME<br><b>Richard J. Phelps</b>   |                                 |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Ann Boone</b>  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>  |                                 | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><b>Bernard Bertling Abame</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Exsanguination from Rupture of Aorta</b><br>DUE TO (b) <b>Trauma from Auto Accident.</b><br>DUE TO (c) <b>lost.</b>   |                                 |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 1/4 hrs.</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTR. BLTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Passenger in car that ran off road and struck a pole</b>   |                                 |   |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                                 | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)<br><b>Passenger in car that ran off road and struck a pole</b> |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>8:45</b> p.m. <b>4/13</b> 19 <b>67</b>  |                                 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Highway</b>                |  |
| 20f. (City or town)<br><b>R. Clarksville</b>  |                                 | 20g. (County)<br><b>Howard</b>  |  | 20h. (State)<br><b>MD</b>   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                 |   |  |   |  |
| ACTUAL SIGNATURE<br><b>John S. Ball</b>   |                                 | M.D.  |  | 22. DATE SIGNED<br><b>4/14/67</b>   |  |
| EXAMINER'S NAME (Type)<br><b>John S. Ball</b>   |                                 | Address (Street, city, town, or county)<br><b>Calmar Manor Md</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                 | 23b. DATE THEREOF<br><b>4-17-67</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Fort Lincoln</b>   |  |
| 23d. LOCATION (City or Town)<br><b>Calmar Manor Md</b>  |                                 | 23e. (County)<br><b>Howard</b>  |  | 23f. (State)<br><b>MD</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Wm. A. Ball</b>  |                                 | ADDRESS<br><b>Wm. A. Ball</b>   |  | 25a. REC'D BY REGISTRAR<br><b>APR 20 1967</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John S. Ball</b>   |                                 |   |  |   |  |



05453

CERTIFICATE OF DEATH

05456

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |   |   |   |
|---|---|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND  |   | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>   |   | c. LENGTH OF STAY IN 1b <u>SILVER SPRING</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>   |   | d. STREET ADDRESS <u>2110 DEXTER AVE.</u>   |   |
| 3 NAME OF DECEASED (Type or print) <u>FANNIE</u> First Middle Last  |   | 4 DATE OF DEATH <u>APRIL 22</u> 19 <u>67</u> Month Day Year   |   |
| 5 SEX <u>F</u>  | 6 COLOR OR RACE <u>W</u>  | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4/10/88</u> 9 AGE (n years last birthday) <u>79</u> yrs.                  |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |   | 10b KIND OF BUSINESS OR INDUSTRY <u>-----</u>   | 11 BIRTHPLACE (County & State, or foreign country) <u>AUSTRIA</u>                             |
| 13. FATHER'S NAME <u>Abraham Silber</u>   |   | 14 MOTHER'S MAIDEN NAME <u>Anna ? ? ? ?</u>   |   |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>-----</u>   |   | 16 SOCIAL SECURITY NO. <u>None</u>  | 17. INFORMANT <u>Pearle Miller</u> Address <u>8523 Freyman Drive Chevy Chase, Maryland</u>    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral anoxia</u><br>DUE TO (b) <u>Cerebral metastasis</u><br>DUE TO (c) <u>Carcinoma breast</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   | INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |   |   | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |   |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>   | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov 7, 1966</u> to <u>April 22, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 21, 1967</u> , and that death occurred at <u>10:28</u> M, from causes and on the date stated above.   |   |   |   |
| 22a SIGNATURE <u>Edward J. Richards</u> M.D.  |   | 22b DATE SIGNED <u>4-22-67</u>  |   |
| 22c. PHYSICIAN'S NAME (Type) <u>Edward J. Richards</u>  |   | 22d ADDRESS <u>10110 Ga. Ave., Silver Spring, Md.</u>   |   |
| 23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 23b. DATE THEREOF <u>4-23-1967</u>  | 23c NAME OF CEMETERY OR CREMATORY <u>Agudath Achim Cemetery</u>   | 23d LOCATION (City or Town) (County) (State) <u>Lorain County, Ohio</u>                       |
| 24 FUNERAL DIRECTOR <u>Goldberg Funeral Home</u> ADDRESS <u>4217 9th St., N.W.</u>  |   | 25a REC'D BY REGISTRAR <u>APR 24 1967</u>   | 25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |



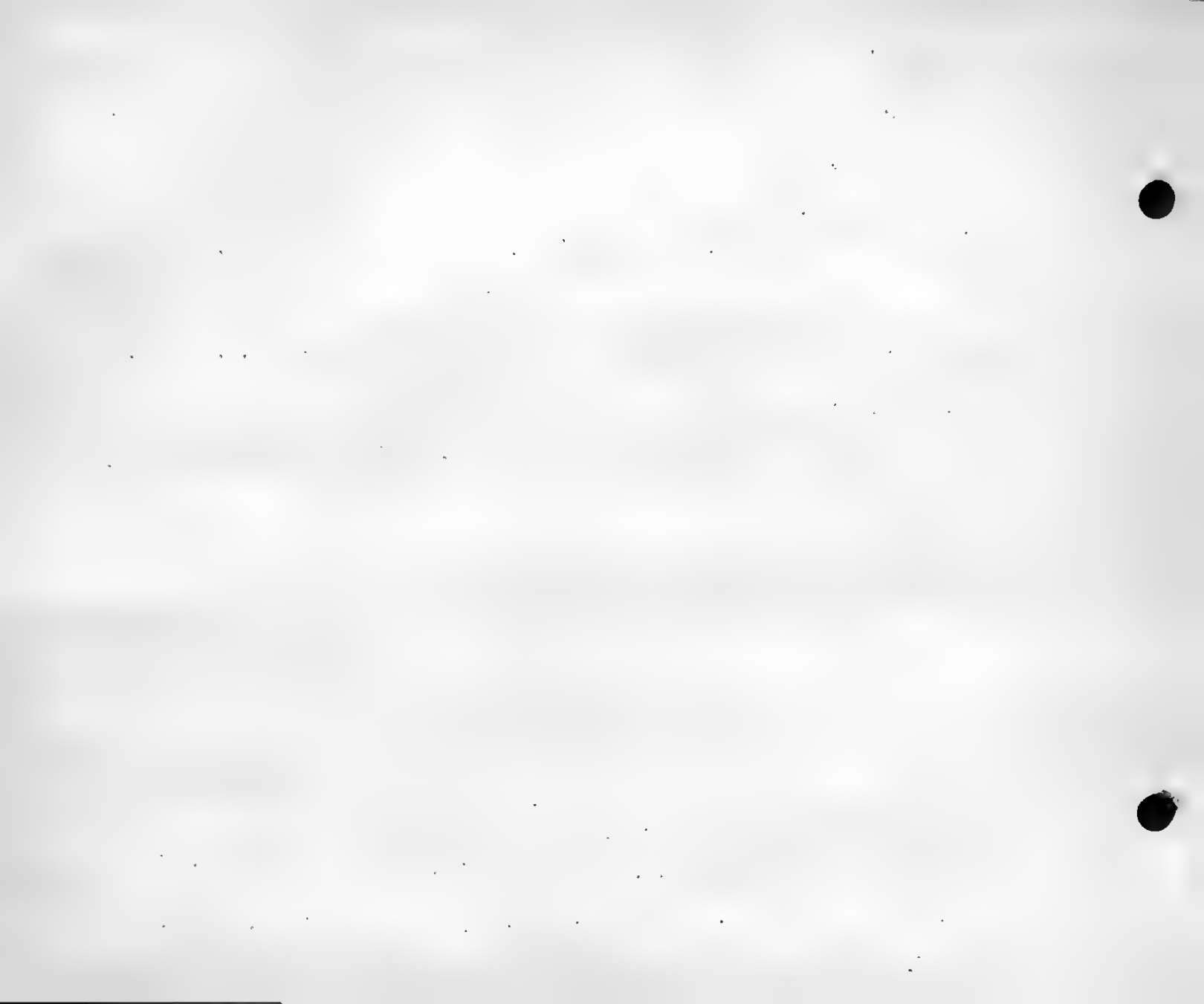
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3, Page 5 may be retained for your files.

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VR A1SME (5)  
5M 1/65

| <div> <div>10-1 Film 500 5-11-67</div> <div> <div>05459</div> <div>05457</div> </div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div>  |  |                               |  |  |  |   |  |  |  |   |  |
|--|--|-------------------------------|--|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u><br>c. LENGTH OF STAY IN 1b <u>15 1/2</u> years<br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>211 Springbrook Drive</u>   |  |                               |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u><br>d. STREET ADDRESS <u>211 Springbrook Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |   |  |
| 3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Virginia</u> Last <u>Pilgrim</u>   |  |                               |  |  |  | 4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>1967</u>  |  |  |  |   |  |
| 5. SEX <u>Fe</u>   |  | 6. COLOR OR RACE <u>White</u> |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>2-4-1908</u>  |  | 9. AGE (In years last birthday) <u>59</u> yrs.                                   |  | IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |  |                               |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>  |  | 11. BIRTHPLACE (State or foreign country) <u>Martins Ferry, Ohio</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>                                     |  |   |  |
| 13. FATHER'S NAME <u>Thomas H. Jarvis</u>  |  |                               |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Lucy Sedgwick</u>   |  |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>  |  |                               |  | 16. SOCIAL SECURITY NO. <u>212-32-1594</u>   |  | 17. INFORMANT <u>Dennis C. Pilgrim</u> Address <u>10020 Brookmoor Drive Silver Spring, Md.</u>  |  |  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary edema</u><br><u>7160</u> DUE TO (b) <u>Smoke inhalation</u> Few minutes<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>  </u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary edema</u><br>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                               |  |  |  |   |  |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |                               |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Found in her burned out bedroom</u>                      |  |   |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>4</u> min. <u>21</u> p.m. <u>1967</u>   |  |                               |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>  |  | 20f. (City or town) <u>Silver Spring</u> (County) <u>Mont</u> (State) <u>Md.</u> |  |   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>   |  |                               |  |  |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <u>John S. Rogers, M.D.</u><br>EXAMINER'S NAME (Type) <u>John S. Rogers, M.D.</u>   |  |                               |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>22. DATE SIGNED <u>4-21-67</u>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>   |  |                               |  | 23b. DATE THEREOF <u>Apr 26, 1967</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>   |  | 23d. LOCATION (City, town or county) (State) <u>Rockville, Maryland</u>          |  |   |  |
| 24. FUNERAL DIRECTOR <u>John B. Thomas</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>   |  |                               |  |  |  | 25a. REC'D BY REGISTRAR <u>APR 27 1967</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>                                  |  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

|  |  |                                    |  |   |  |  |  |   |  |  |  |
|--|--|------------------------------------|--|---|--|--|--|---|--|--|--|
| 05460<br>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201<br>05458   |  |                                    |  |   |  |  |  |   |  |  |  |
| 1 PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  |                                    |  |   |  | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> |  |   |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>   |  |                                    |  | c. LENGTH OF STAY IN 1b   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u> 15-1                                |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>12504 Farnell Drive</u>   |  |                                    |  |   |  | d. STREET ADDRESS<br><u>12504 Farnell Drive</u>  |  |   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Theodore</u> Middle <u>K.</u> Last <u>Piotrowski</u>   |  |                                    |  |   |  | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>27</u> Year <u>1967</u>  |  |   |  |  |  |
| 5. SEX<br><u>Male</u>  |  | 6. COLOR OR RACE<br><u>White</u>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>July 16, 1910</u>   |  | 9. AGE (In years last birthday)<br><u>56</u> yrs                                  |  | 10. IF UNDER 1 YEAR<br>Months <u>3</u> Days <u>11</u> Hours <u></u> Min. <u></u>       |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Mechanic</u>   |  |                                    |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Poland</u>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |
| 13. FATHER'S NAME<br><u>Unknown</u>  |  |                                    |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Unknown</u>   |  |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |  |                                    |  | 16. SOCIAL SECURITY NO  |  | 17. INFORMANT<br><u>Gladys A. Piotrowski - wife - same item</u>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u><br>DUE TO (b) <u>Hypertensive arteriosclerotic heart disease</u><br>DUE TO (c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                    |  |   |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 years</u>                                     |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>Diabetes Mellitus</u>   |  |                                    |  |   |  |  |  |   |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                                    |  |   |  |  |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                    |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |  |  |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m. <u></u>   |  |                                    |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |  |  |
| 21. I certify that (1) (the hospital) attended the deceased from <u>3/25, 1967</u> to <u>April 27, 1967</u> that (1) (the) last saw the deceased alive on <u>April 25, 1967</u> , and that death occurred at <u>8:50 AM</u> , from causes and on the date stated above.  |  |                                    |  |   |  |  |  |   |  |  |  |
| 22a. SIGNATURE<br><u>Michael R. Dobridge</u>   |  |                                    |  |   |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>         |  | 22b. DATE SIGNED<br><u>April 27, 1967</u>   |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Michael R. Dobridge</u>   |  |                                    |  |   |  | 22d. ADDRESS<br><u>12504 Farnell Drive, Rockville, Md.</u>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 23b. DATE THEREOF<br><u>5/1/67</u> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Parkland Cemetery</u>  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Silver Spring, Montg. Md.</u> |  |  |  |
| 24. FUNERAL DIRECTOR<br><u>John Wheeler Funeral Home</u>   |  |                                    |  |   |  | ADDRESS<br><u>1331 Rockville Road, Rockville, Md.</u>  |  | 25a. REC'D BY REGISTRAR<br><u>MAY 1 1967</u>                                      |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                                     |  |



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |  |  |  |  |  |   |  |  |  |  |  |
|---|--|--|--|--|--|---|--|--|--|--|--|
| Item 18 Film 390 6-22-67 MARYLAND STATE DEPARTMENT OF HEALTH<br>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |   |  |  |  |  |  |
| 05461 MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>c. LENGTH OF STAY IN b<br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)   |  |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)<br>a. STATE<br>b. COUNTY<br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>d. STREET ADDRESS<br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>4. DATE OF DEATH<br>5. SEX<br>6. COLOR OR RACE<br>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  |  |  |  | 8. DATE OF BIRTH<br>9. AGE (In years last birthday)<br>10. USULA OCCUPATION (Give kind of work done during most of working life, even if retired)<br>11. BIRTHPLACE (State or foreign country)<br>12. CITIZEN OF WHAT COUNTRY?  |  |  |  |  |  |
| 13. FATHER'S NAME<br>14. MOTHER'S MAIDEN NAME<br>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>16. SOCIAL SECURITY NO.<br>17. INFORMANT   |  |  |  |  |  | Address 118 Alleghany Rd Manassas, Va<br>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gunshot wound through chest and heart<br>(b) with exsanguination<br>(c)   |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |   |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |   |  |  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)<br>20c. TIME OF INJURY Month, Day, Year<br>20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work<br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |  |  |  |  |  |   |  |  |  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>  |  |  |  |  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)<br>22. DATE SIGNED   |  |  |  |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>23b. DATE THEREOF<br>23c. NAME OF CEMETERY OR CREMATORY<br>23d. LOCATION (City or town) (County) (State)   |  |  |  |  |  |   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>25a. REC'D BY REGISTRAR<br>25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |   |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

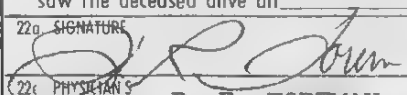

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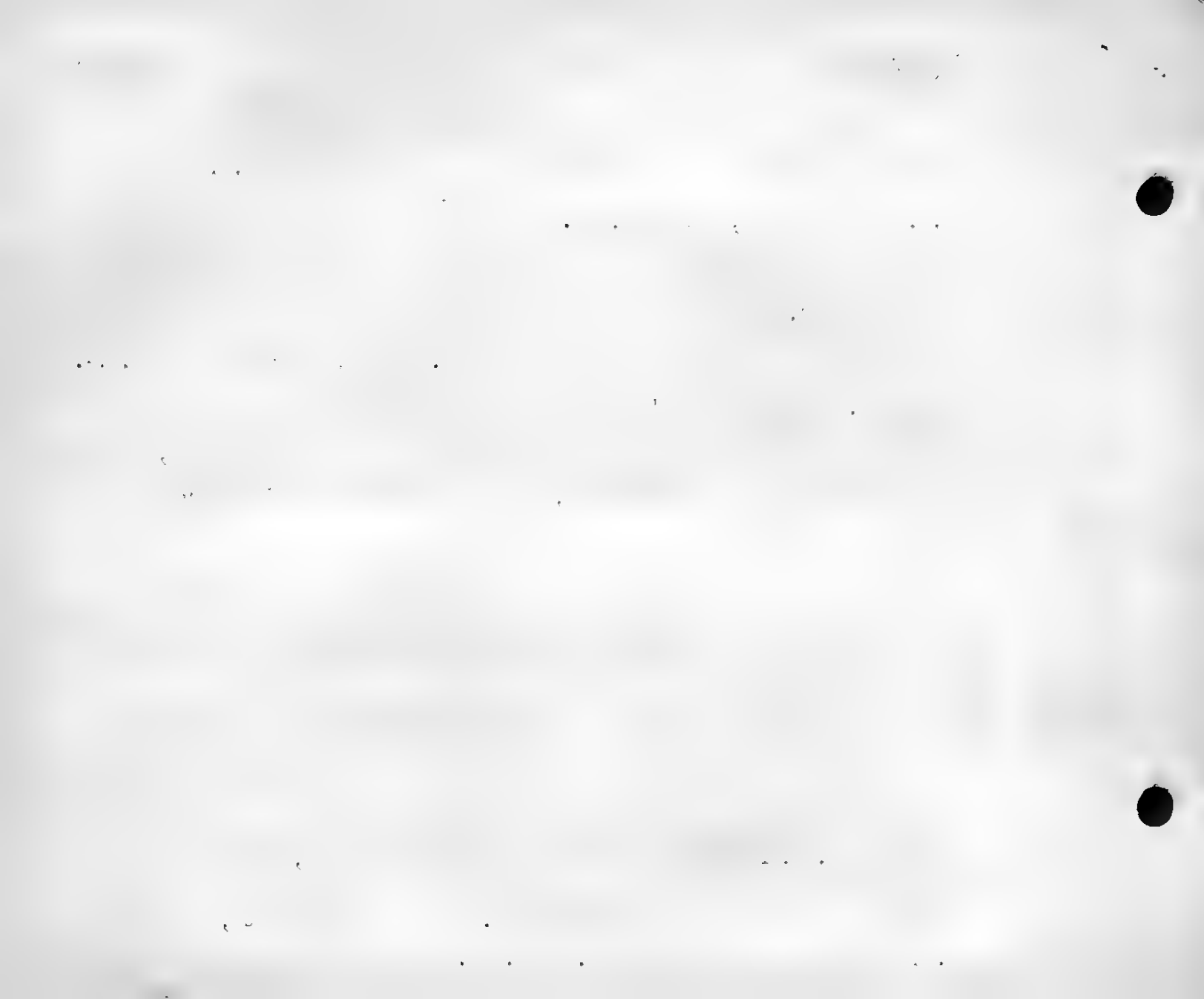
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05462

CERTIFICATE OF DEATH

05460

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(RURAL) BETHESDA</b><br>c. LENGTH OF STAY IN lb <b>5 DAYS</b>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY <b>DISTRICT OF COLUMBIA</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>6200 OREGON AVENUE N.W.</b> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. NAVAL HOSPITAL, BETHESDA, MD.</b>   |  | d. STREET ADDRESS <b>ARMY DISTAFF HALL</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>KATHERINE</b> Middle <b>PRIEST</b> Last <b>PRIEST</b>  |  | 4. DATE OF DEATH<br>Month <b>APRIL</b> Day <b>26</b> Year <b>19 67</b>   |  |
| 5. SEX <b>FEMALE</b>   | 6. COLOR OR RACE <b>CAUC.</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <b>JAN 31, 1885</b>   |
| 9. AGE (In years and birthdate yrs.) <b>82</b>   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country) <b>ST. JOSEPH, MISSOURI</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 13. FATHER'S NAME <b>ROBERT W. DOWDY (DEC'D)</b>   |  | 14. MOTHER'S MAIDEN NAME <b>ANNIE CLARKson (DEC'D)</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>  |  | 16. SOCIAL SECURITY NO. <b>229 60 0334</b>   |  |
| 17. INFORMANT <b>NAVY RECORDS</b>  |  | Address <b>USNH BETHESDA, MARYLAND</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>440X HYPERTENSIVE, ARTERIOSCHLEROTIC CARDIOVASCULAR DISEASE</b><br>DUE TO <b>DISEASE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) _____<br>(c) _____ |  |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____<br>p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.   |  |  |  |
| 22a. SIGNATURE <br>22c. PHYSICIAN'S NAME (Type) <b>D. R. FOREMAN</b>  |  | 22b. DATE SIGNED <b>APRIL 27, 1967</b><br>22d. ADDRESS <b>USNH BETHESDA, MARYLAND</b>  |  |
| 23a. BURIAL, CREMATION, REPAULSATION <b>BURIAL</b>   | 23b. DATE THEREOF <b>5-1-67</b>  | 23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NAT. CEMETERY</b>  | 23d. LOCATION (City or Town) (County) (State) <b>ARLINGTON, VIRGINIA</b>   |
| 24. FUNERAL DIRECTOR <b>R.A. PUMPHREY 7557 WISCONSIN AVE. BETH. MD.</b>  |  | 25a. REC'D BY REGISTRAR <b>May 3 1967</b>  | 25b. REGISTRAR'S SIGNATURE  |



05463

## CERTIFICATE OF DEATH

05461

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>D.C.</u> b. COUNTY                                      |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Kensington</u>   |   | c. LENGTH OF STAY IN lb<br><u>18 days</u>   |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Washington</u>   |   | d. STREET ADDRESS<br><u>5308 Augusta St</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Kensington Gardens</u>   |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>ANNA</u> Middle <u>D.</u> Last <u>Prime</u>   |   | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>18</u> Year <u>1967</u>   |  |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Feb 25 1877</u>                                     |
| 9. AGE (In years last birthday)<br><u>90</u> yrs  |   | 10. IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>New York</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S.</u>  |  |
| 13. FATHER'S NAME<br><u>Henry Davidson</u>  |   | 14. MOTHER'S MAIDEN NAME<br><u>Seath</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |   | 16. SOCIAL SECURITY NO<br><u>577-68-6314J1</u>  |  |
| 17. INFORMANT<br><u>Son Charles R. Prime</u>  |   | <u>5308 Augusta St. Washington, D. C.</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u><br>DUE TO <u>HYPOSTATIC PNEUMONIA</u><br>(b) <u>CEREBROVASCULAR ARTERIOSCLEROSIS</u><br>DUE TO <u>  </u><br>(c) <u>  </u> |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 DAYS</u><br><u>10 YEARS</u>       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I(a) -<br><u>Generalized arteriosclerosis. Old hip fracture.</u>   |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                       |
| 21. I certify that (I) (this hospital) attended the deceased from <u>JULY</u> , 1961, to <u>APRIL 18</u> , 1967, that (I) <u>live</u> last saw the deceased alive on <u>April 6</u> , 1967, and that death occurred at <u>3:50 PM</u> , from causes and on the date stated above.   |   |   |  |
| 22a. SIGNATURE<br><u>Joseph D. Connor, M.D.</u>   |   | 22b. DATE SIGNED<br><u>4-18-67</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>JOSEPH D. CONNOR, M.D.</u>   |   | 22d. ADDRESS<br><u>9420 Oak Crest Dr Bethesda, Md.</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Cremation</u>   | 23b. DATE THEREOF<br><u>4-20-67</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Hill Crematory</u>   | 23d. LOCATION (City or Town) (County) (State)<br><u>Suitland, Maryland</u> |
| 24. FUNERAL DIRECTOR<br><u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>   |   | 25a. REC'D BY REGISTRAR<br><u>APR 24 1967</u>   |  |
|   |   | 25b. REGISTRAR'S SIGNATURE<br><u>James Judge</u>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.







MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05464

CERTIFICATE OF DEATH

05462

|  |  |   |   |
|--|--|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admision)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>Frederick</b>                  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>TAKOMA PARK</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FREDERICK</b>  |   |
| c. LENGTH OF STAY IN Tb<br><b>6 days</b>   |  | d. STREET ADDRESS<br><b>5132 White Rock Ave.</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>WASHINGTON SANITARIUM &amp; HOSPITAL</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3 NAME OF DECEASED<br>(Type or print) <b>STANLEY MOODY PRYOR</b>   |  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>9</b> Year <b>1967</b>  |   |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WH</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10/17/79</b>   |
| 9. AGE (in years lost birthday) yrs. <b>87</b>   |  | 10. IF UNDER 1 YEAR<br>Months <b>9</b> Days <b>9</b> Hours <b>19</b> Min. <b>67</b>   |   |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>STONE MASON</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>SAMUEL PRYOR</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Louise Cline</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO  |   |
| 17. INFORMANT<br><b>HOSPITAL RECORDS</b>   |  | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Myocardial Terminal</b><br>DUE TO<br>(b) <b>ASHD &amp; congestive heart failure</b><br>DUE TO<br>(c) <b>Diabetes Mellitus</b>  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 years</b><br><b>3 years</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>4/3</b> , 19 <b>67</b> , to <b>4/9</b> , 19 <b>67</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>4/9</b> , 19 <b>67</b> , and that death occurred at <b>5:00</b> P.M. from causes and on the date stated above. |  |   |   |
| 22a. SIGNATURE<br>  |  | 22b. DATE SIGNED  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. Hugh Trey</b>   |  | 22d. ADDRESS<br><b>7105 - RIGGS RD, HYATTSVILLE MD.</b>   |   |
| 23a. BURIAL (CREMATION, REMOVAL) (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>4-12-67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bethel Church of God</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Cascade, Md. Fred. Co.</b>                                      |
| 24. FUNERAL DIRECTOR<br><b>Raymond E. Greager</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 13 1967</b>  | 25b. REGISTRAR'S SIGNATURE<br> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05463

CERTIFICATE OF DEATH

05463

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>Montgomery</i><br>MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><i>Maryland</i><br>b. COUNTY<br><i>Montgomery</i>      |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><i>Garrett Park</i>  |  |   |  | c. LENGTH OF STAY IN 1b<br><i>62 years</i>  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><i>11006 Kenilworth Avenue</i>   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br><i>Jane</i>   |  | First<br><i>Carroll</i>   |  | Middle<br><i>Putnam</i>   |  | Last<br><i>Putnam</i>  |  |
| 4. DATE OF DEATH<br><i>April</i>   |  | Month<br><i>8</i>   |  | Day<br><i>19</i>  |  | Year<br><i>67</i>  |  |
| 5. SEX<br><i>female</i>  |  | 6. COLOR OR RACE<br><i>white</i>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><i>Feb 24, 1883</i>                                    |  |
| 9. AGE (In years last birthday)<br><i>84</i> yrs.  |  | IF UNDER 1 YEAR<br>Months<br>Days<br>Hours<br>Min.  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><i>Virginia</i>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                              |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Own home</i>  |  |  |  |
| 13. FATHER'S NAME<br><i>John P. Gouldman</i>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><i>Alma Smith</i>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><i>No</i>   |  |   |  | 16. SOCIAL SECURITY NO.<br><i>217-05-9512-D</i>   |  | 17. INFORMANT<br><i>Jane C. Putnam</i>                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i><br><i>4500</i><br>DUE TO (b) <i>Arteriosclerosis - Atherosclerosis</i><br>DUE TO (c) <i>Serility - Gg. 84</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>2-3 days</i><br><i>years</i><br><i>years</i>   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><i>Carotid Artery - Atherosclerosis</i>   |  |   |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br><i>19</i>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                       |  |
| 21. I certify that (I) (this hospital) attended the deceased from <i>3/7/67</i> , 19 <i>67</i> , to <i>4/8/67</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>4/7/67</i> , 19 <i>67</i> , and that death occurred at <i>4:45</i> M. on the causes and on the date stated above.   |  |   |  |   |  |  |  |
| 22a. SIGNATURE<br><i>Sam Allen</i>   |  |   |  | 22b. DATE SIGNED<br><i>4/8/67</i>   |  | 22c. PHYSICIAN'S NAME (Type)<br><i>SAM ALLEN, M. D.</i>                    |  |
| 22d. ADDRESS<br><i>Kensington</i>  |  |   |  | 22e. MED. PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  | 22f. ADDRESS   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |  | 23b. DATE THEREOF<br><i>Apr 12, 1967</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Arlington Nat'l Cemetery</i>   |  | 23d. LOCATION (City, town or county) (State)<br><i>Arlington, Virginia</i> |  |
| 24. FUNERAL DIRECTOR<br><i>John B. Thomas</i>  |  |   |  | 25a. REC'D BY REGISTRAR<br><i>APR 12 1967</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                         |  |
| 25c. ADDRESS<br><i>Warner E. Humphrey, Inc. Silver Spring, Md.</i>   |  |   |  | 25d. ADDRESS  |  |  |  |

MEDICAL CERTIFICATION



# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05466

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05464

|   |  |   |                                      |
|---|--|---|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Mont.</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>                         |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>   |  | c. LENGTH OF STAY IN 1b<br><u>S.O.A.</u>  |                                      |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Suburban</u>   |  | d. STREET ADDRESS<br><u>17705 Cliffbourne Lane</u>  |                                      |
| 3. NAME OF DECEASED<br>(Type or print)<br><u>Raymond A. Raskis</u>  |  | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>13</u> Year <u>1967</u>   |                                      |
| 5. SEX<br><u>male</u>   | 6. COLOR OR RACE<br><u>white</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>6/26/29</u>   |
| 9. AGE (In years - last birthday)<br><u>37</u> yrs  |  | 10. IF UNDER 1 YEAR<br>Months <u>13</u> Days <u>19</u> Hours <u>67</u> Min  |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Registrar</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>computer school teacher</u>   |                                      |
| 11. BIRTHPLACE (State or foreign country)<br><u>U.S.A.</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |                                      |
| 13. FATHER'S NAME<br><u>James J. Raskis</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>Rose M. Adamany</u>  |                                      |
| 15. WAS DECEASED EVER U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give year or dates of service)<br><u>Yes</u> <u>WWII</u>  |  | 16. SOCIAL SECURITY NO<br><u>---</u>  |                                      |
| 17. INFORMANT<br><u>Kenneth R. Raskis</u>   |  | Address <u>Wash. DC</u><br><u>1255-114 Ave NW</u>   |                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Congestive Heart Failure - Acute</u><br>DUE TO (b) <u>Pericarditis - old + Recent</u><br>DUE TO (c) <u>Sudden</u>  |  |   |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |                                      |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)  |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>hour a.m. <u>19</u> p.m.  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>of work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)  | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |                                      |
| ACTUAL SIGNATURE<br><u>John S. Ball</u>   |  | 22. DATE SIGNED<br><u>4/14/67</u>   |                                      |
| EXAMINER'S NAME (Type)<br><u>John S. Ball</u>   |  | 22. DATE SIGNED<br><u>4/14/67</u>   |                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 23b. DATE THEREOF<br><u>4-17-1967</u>   |                                      |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Gate of Heaven Cem.</u>  |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Silver Spring, Md.</u>  |                                      |
| 24. FUNERAL DIRECTOR<br><u>Joseph Gawler's Sons, Inc.</u><br><u>5130 Wisc. Ave. N.W. Wash. D.C.</u>   |  | 25a. REC'D BY REGISTRAR<br><u>Charles Judge</u><br>DATE <u>APR 20 1967</u>  |                                      |



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

05467

05465

|  |                                  |   |  |   |  |   |  |
|--|----------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Montg</u> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Gaithersburg</u>  |                                  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Gaithersburg</u>                             |  |   |  |
| c. LENGTH OF STAY IN IS<br><u>19Yrs</u>  |                                  |   |  | d. STREET ADDRESS<br><u>35 S. Summit Ave</u>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)   |                                  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)   |                                  | First <u>James</u> Middle <u>Gilbert</u> Last <u>Reid</u>   |  | 4. DATE OF DEATH<br>Month <u>Apr</u> Day <u>27th</u> Year <u>1967</u>   |  |   |  |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Nov 23rd 1905</u> | 9. AGE (in years last birthday)<br><u>61</u> yrs.   | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u>              |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Ret. Co. Rd. Emp.</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Boyd. Md.</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U S A</u>                    |  |
| 13. FATHER'S NAME<br><u>James A. Reid</u>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Debrah Burdette</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><u>Richard S. Reid, Gaithersburg.</u>  |  | Address <u>  </u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u><br>DUE TO (b) <u>ARTERIO SCLEROTIC</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Heart Disease</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> |                                  |   |  |   |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                            |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>4-27-67</u> 19 <u>67</u> to <u>4-28-67</u> 19 <u>67</u> , that (I) <u>was</u> saw the deceased alive on <u>4-27-67</u> , and that death occurred at <u>3:40</u> P. M. from the causes and on the date stated above.   |                                  |   |  |   |  |   |  |
| 22a. SIGNATURE<br><u>Jack Schumacher</u> M.D.<br>PHYSICIAN'S NAME (Type)   |                                  | 22b. DATE SIGNED<br><u>4-28-67</u>  |  | 22c. ADDRESS<br><u>Gaithersburg. Md.</u>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 23b. DATE THEREOF<br><u>5-1-67</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Presbyterian Ch.</u>   |  | 23d. LOCATION (City, town or county) (State)<br><u>Boyd. Md</u> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>Ernest C. Gartner</u><br><u>Ernest C. Gartner</u>   |                                  | ADDRESS<br><u>Gaithersburg. Md.</u>   |  | 25a. REC'D BY REGISTRAR<br><u>MAY 2 1967</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>              |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

95468

CERTIFICATE OF DEATH

05466

|   |   |   |   |  |   |
|---|---|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Takoma Park</u>  |   |   | c. LENGTH OF STAY IN 1b<br><u>12 days</u>   |  |   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>  |   |   | d. STREET ADDRESS<br><u>3304 Jeller Road</u>  |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Washington Sanitarium and Hospital</u>   |   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>John</u> Middle <u>Henry</u> Last <u>Rhine</u>  |   |   | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>13</u> Year <u>1967</u>   |  |   |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>11-11-92</u>   | 9. AGE (In years last birthday)<br><u>74</u> yrs                       | IF UNDER 1 YEAR<br>Months <u>13</u> Days <u>19</u> Hours <u>67</u> Min.                           |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired printer</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Govt. Printing Off.</u>   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Maryland</u> |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>America</u>  |   |   | 13. FATHER'S NAME<br><u>Joseph Rhine</u>  |  |   |
| 14. MOTHER'S MAIDEN NAME<br><u>Octavia Cronise</u>  |   |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>no</u> <u>None</u>              |  |   |
| 16. SOCIAL SECURITY NO.<br><u>220-111-0151</u>  |   |   | 17. INFORMANT<br><u>Hazel H. Rhine</u> <u>3304 Jeller Road Silver Spring, Md.</u>   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cancer of the Pancreas</u><br>DUE TO (b) _____<br>DUE TO (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <u>19</u>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)   | (County)   | (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>62</u> , to <u>April 13</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>April 12</u> , 19 <u>67</u> , and that death occurred at <u>1230 AM</u> , from causes and on the date stated above.   |   |   |   |  |   |
| 22a. SIGNATURE<br><u>R. H. Sandstrom MD</u>   |   |   | 22b. DATE SIGNED<br><u>4-13-67</u>  |  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>R. H. Sandstrom MD</u>   |   |   | 22d. ADDRESS<br><u>7701 Carroll Ave Takoma Park, Md</u>   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 23b. DATE THEREOF<br><u>April 15, 1967</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Rock Creek Cemetery</u>  | 23d. LOCATION (City or Town)  | (County)   | (State)   |
| 23e. FUNERAL DIRECTOR<br><u>Warner E. Humphrey, Inc.</u>  |   |   | 23f. ADDRESS<br><u>434 Georgia Avenue Silver Spring, Md.</u>  |  |   |
| 25a. REC'D BY REGISTRAR<br>DATE <u>APR 17 1967</u>  |   |   | 25b. REGISTRAR'S SIGNATURE<br><u>J. Charles Judge</u>   |  |   |



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

35469

CERTIFICATE OF DEATH

|  |   |  |   |
|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Tahoma Park</u><br>c. LENGTH OF STAY (If in hospital, give street address)<br><u>18 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Washington Sanitarium - Hospital</u>  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE<br><u>Maryland</u><br>b. COUNTY<br><u>Montgomery</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Tahoma Park</u><br>d. STREET ADDRESS<br><u>7207 Maple Avenue</u><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><u>Mrs. Edyth Barbara Rice</u>   |   | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>6</u> Year <u>1967</u>   |   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><u>10-21-91</u>                                     |
| 9. AGE (In years lost birthday)<br><u>75 yrs</u>   |   | 10. IF UNDER 1 YEAR<br>Months <u>18</u> Days <u>2</u>  |   |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |   | 12. KIND OF BUSINESS OR INDUSTRY<br><u>None</u>  |   |
| 13. BIRTHPLACE (County & State, or foreign country)<br><u>Maryland</u>   |   | 14. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |   |
| 15. FATHER'S NAME<br><u>Harry Walter</u>   |   | 16. MOTHER'S MAIDEN NAME<br><u>Mary Jones</u>  |   |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown) (If yes give war or dates of service)  |   | 18. SOCIAL SECURITY NO.<br><u>Unknown</u>  |   |
| 19. INFORMANT<br><u>Records - Washington Sanitarium - Hospital</u>   |   | Address<br><u>Washington Sanitarium - Hospital</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4000 Hypostatic Pneumonia -</u><br>DUE TO <u>Cerebral Thrombosis</u><br>(b) <u>Chronic Myocarditis</u><br>DUE TO <u>Long Standing Hypertension</u><br>(c) <u>Chronic Myocarditis</u><br>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Chronic Myocarditis</u><br>INTERVAL BETWEEN ONSET AND DEATH<br><u>18 days</u><br><u>7 1/2 months</u> |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m. <u>6/6/67</u>   | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/><br>at work <input checked="" type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>Home</u>  | 20f. (City or town) (County) (State)<br><u>Washington D.C.</u>          |
| 21. I certify that (I) (this hospital) attended the deceased from <u>6/6/67</u> to <u>6/6/67</u> , that (I) (we) lost saw the deceased alive on <u>6/6/67</u> , and that death occurred at <u>7:30</u> M, from causes and on the date stated above.  |   |  |   |
| 22a. SIGNATURE<br><u>Howard T. Morse</u>   |   | 22b. DATE SIGNED<br><u>4/6/67</u>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>HOWARD T. MORSE</u>   |   | 22d. ADDRESS<br><u>7030 Carroll Ave - Tahoma Park Md</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 23b. DATE THEREOF<br><u>April 10, 1967</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Prospect Hill Cemetery</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>Washington D.C.</u> |
| 24. FUNERAL DIRECTOR<br><u>J. Arthur Walters, 254 Carroll NW</u>   |   | 25. DATE<br><u>APR 10 1967</u>   |   |
|  |   | 26. REG. STRAUS'S SIGNATURE<br><u>[Signature]</u>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05470

CERTIFICATE OF DEATH

05468

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove page 1 and 2 and be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |                           |   |                                       |
|--|---------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u><br>c. LENGTH OF STAY IN 1b <u>MD.</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Beth. Silva Spring Nursing Home 3708 Warner Rd.</u>  |                           | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence outside institution)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase Md.</u><br>d. STREET ADDRESS <u>3708 Warner Rd.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                       |
| 3. NAME OF DECEASED (Type or print) <u>Hermine E. Rice</u>   |                           | 4. DATE OF DEATH <u>4 17 1967</u>   |                                       |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <u>Sept. 8, 1897</u> |
| 9. AGE (In years last birthday) <u>69</u> yrs.   |                           | IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>   |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>Penna.</u>   |                                       |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Penna.</u>  |                           | 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>   |                                       |
| 13. FATHER'S NAME <u>Paul R. Hilleman</u>  |                           | 14. MOTHER'S MAIDEN NAME <u>Auguste Guenther</u>  |                                       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)  |                           | 16. SOCIAL SECURITY NO. <u>220-50-5459</u>  |                                       |
| 17. INFORMANT <u>Husband</u>   |                           | Address <u>Same as Item 2.</u>  |                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hepatic coma</u><br>DUE TO <u>Cirrhosis of liver</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>None</u> |                           |   |                                       |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                           |   |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>  |                                       |
| 20c. TIME OF INJURY Month, Day, Year <u>19</u><br>Hour a.m. <u>  </u> p.m. <u>  </u>   |                           | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>   |                           | 20f. (City or town) (County) (State) <u>  </u>  |                                       |
| 21. I certify that (1) (this hospital) attended the deceased from <u>1964</u> to <u>present</u> , that (2) (we) last saw the deceased alive on <u>4/17 1967</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.   |                           |   |                                       |
| 22a. SIGNATURE <u>John B. Umhauer</u> M.D.   |                           | 22b. DATE SIGNED <u>4-17-67</u>   |                                       |
| 22c. PHYSICIAN'S NAME (Type) <u>JOHN B UMHAU</u>   |                           | 22d. ADDRESS <u>5805 Conn. Ave. Ch. Ch. Md.</u>   |                                       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                           | 23b. DATE THEREOF <u>4-22-67</u>  |                                       |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Home Wood Mausoleum</u>  |                           | 23d. LOCATION (City, town or county) (State) <u>Pittsburgh, Penna.</u>  |                                       |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>   |                           | 25a. REC'D BY REGISTRAR <u>APR 24 1967</u>  |                                       |
| ADDRESS <u>Bethesda, Maryland</u>  |                           | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>   |                                       |



05471

## CERTIFICATE OF DEATH

05469

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>a COUNTY <u>Montgomery</u> MARYLAND   |  | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a STATE <u>Tennessee</u> b COUNTY <u>✓</u>   |   |
| b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)<br><u>Bethesda</u>  |  | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Louisville</u>   |   |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>The Clinical Center, Bethesda, Maryland</u>  |  | d STREET ADDRESS<br><u>Route # 1</u>   |   |
| 3 NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>Lillian Leona Richardson</u>   |  | 4 DATE OF DEATH<br>Month Day Year<br><u>April 10 19 67</u>   |   |
| 5 SEX<br><u>Female</u>   | 6 COLOR OR RACE<br><u>White</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    | 8. DATE OF BIRTH<br><u>January 23, 1923</u>   |
| 9. AGE (In years last birthday) yrs.<br><u>44</u>  |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.<br><u>10 19 67</u>   |   |
| 10a USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)<br><u>Housewife</u>  |  | 10b KIND OF BUSINESS OR INDUSTRY<br><u>Not employed</u>  |   |
| 11 BIRTHPLACE (County & State, or foreign country)<br><u>Tennessee</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |   |
| 13 FATHER'S NAME<br><u>Azer Lane</u>   |  | 14 MOTHER'S MAIDEN NAME<br><u>Victoria Moore</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |  | 16. SOCIAL SECURITY NO<br><u>412-30-8426</u>   |   |
| 17 INFORMANT<br><u>The Medical Record</u>  |  | Address<br><u>The Clinical Center, Bethesda, Maryland 20014</u>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Progressive pulmonary consolidation</u><br>DUE TO<br>(b) <u>Massive blood transfusion &amp; hemolysis</u><br>DUE TO<br>(c) <u>Carcinoma of Cervix</u>                              |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u><br><u>7 days</u><br><u>12 Years</u>             |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that <u>xx</u> (this hospital) attended the deceased from <u>March 21</u> , 19 <u>67</u> , to <u>April 10</u> , 19 <u>67</u> , that <u>xx</u> (we) last saw the deceased alive on <u>April 10</u> , 19 <u>67</u> , and that death occurred at <u>1:35 M.</u> from causes and on the date stated above. |  |  |   |
| 22a SIGNATURE<br><u>James J. Ryan M.D.</u>   |  | 22b. DATE SIGNED<br>AM<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <u>10 April 1967</u> |   |
| 22c PHYSICIAN'S NAME (Type)<br><u>James J. Ryan, MD.</u>   |  | 22d ADDRESS<br><u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>  |   |
| 23a BURIAL, CREMATION, REMOVAL (Specify)<br><u>4-11-67</u>   | 23b DATE THEREOF   | 23c. NAME OF CEMETERY OR CREMATORY   | 23d. LOCATION (City or town) (County) (State)<br><u>MARYVILLE, TENN.</u>                          |
| 24 FUNERAL DIRECTOR<br><u>Frazier 389 B.T. ex h.w. Wash. D.C.</u>  |  | 25a. REC'D BY REGISTRAR<br>DATE <u>APR 14 1967</u>   | 25b REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #8 Film #G388 5/27/67

CERTIFICATE OF DEATH

05472

05470

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission):<br>a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u>                |   |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)<br><u>Bethesda (rural)</u>  |  | c. LENGTH OF STAY IN TB <u>19 Days</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Naval Hospital</u>   |  | d. STREET ADDRESS <u>3909 North 5th Street</u>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Emil</u> Middle <u>James</u> Last <u>Rinaldi</u>  |  | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>23</u> Year <u>1967</u>   |   |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>Cauc.</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Mar. 9, 1912</u> 19 <u>14</u> 53 yrs.   |
| 10a. USIA. OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>USN</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>St. Louis, Missouri</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   |
| 13. FATHER'S NAME<br><u>Michele Rinaldi</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>Louise Bello</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>Yes</u>   |  | 16. SOCIAL SECURITY NO<br><u>490 44 9139</u>  |   |
| 17. INFORMANT<br><u>Arlington Va.</u>   |  | 18. ADDRESS<br><u>Mrs. Patricia M. Rinaldi, 3909 North 5th St.</u>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARCINOMA OF LUNG</u><br>DUE TO<br>(b)<br>DUE TO<br>(c)  |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>19</u> a.m. p.m.  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>April 4</u> , 19 <u>67</u> , to <u>April 23</u> , 19 <u>67</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>April 23</u> , 19 <u>67</u> , and that death occurred at <u>6:15 PM</u> , from causes and on the date stated above. |  |   |   |
| 22a. SIGNATURE<br><u>R.N. Hood</u>  |  | 22b. DATE SIGNED<br><u>Apr. 24, 1967</u>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>R.N. HOOD MD</u>   |  | 22d. ADDRESS<br><u>Naval Hospital, Bethesda, Md.</u>  |   |
| 23a. BURIAL, CREMATION, DISPOSITION (Specify)<br><u>Burial</u>  | 23b. DATE THEREOF<br><u>4/26/67</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Arlington National Cemetery</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>Arlington, Virginia</u>                       |
| 24. FUNERAL DIRECTOR<br><u>Murphy Funeral Home</u><br><u>3524 Columbia Pike, Arlington, Va.</u>   |  | 25a. REC'D BY REGISTRAR<br><u>APR 27 1967</u>   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |



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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

05473

05471

|   |  |  |  |
|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery County</u> MARYLAND<br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>c. LENGTH OF STAY IN b. <u>1 hr</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u> |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges Co.</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>1704 Hannon St. Hyattsville, Md.</u><br>d. STREET ADDRESS                    |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Baby Boy</u><br>First Middle Last  |  | <b>4. DATE OF DEATH</b><br><u>Robert</u> <u>April 9</u> 19 <u>67</u><br>Month Day Year   |  |
| <b>5. SEX</b><br><u>male</u>  |  | <b>6. COLOR OR RACE</b><br><u>White</u>  |  |
| <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>  |  | <b>8. DATE OF BIRTH</b><br><u>April 9, 1967</u>  |  |
| <b>9. AGE</b> (In years (If UNDER 1 YEAR last birthday) Months Days) <u>28</u> yrs. <u>min.</u>   |  | <b>10. BIRTHPLACE</b> (County & State, or foreign country) <u>Montgomery Co., Md.</u>  |  |
| <b>11. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)   |  | <b>12. CITIZEN OF WHAT COUNTRY?</b>  |  |
| <b>13. FATHER'S NAME</b><br><u>Rene Robert</u>  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Jacqueline Plante</u>  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)  |  | <b>16. SOCIAL SECURITY NO.</b>   |  |
| <b>17. INFORMANT</b><br><u>father - Anne</u>  |  | <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Prematurity + multiple congenital anomalies</u><br>DUE TO (b) <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</u><br>DUE TO (c) <u></u> |  |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | <b>20. INTERVAL BETWEEN ONSET AND DEATH</b>  |  |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>  |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>  |  |  |  |
| <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |  | <b>20f. (City or town) (County) (State)</b>  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from <u>April 9, 1967</u> to <u>April 9, 1967</u> that (I) (we) last saw the deceased alive on <u>April 9, 1967</u>, and that death occurred at <u>10 AM</u>, from the causes and on the date stated above.</b>   |  |  |  |
| <b>22a. SIGNATURE</b><br><u>T. Heroult Zerber</u> M.D.  |  | <b>22b. DATE SIGNED</b>  |  |
| <b>22c. PHYSICIAN'S NAME (Type)</b>   |  | <b>22d. ADDRESS</b>  |  |
| <b>23a. BURIAL REMOVAL</b> <input type="checkbox"/> <b>CREMATION</b> <input type="checkbox"/> (Specify) <u>4/10/67</u>  |  | <b>23b. DATE THEREOF</b>   |  |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Suburban Hospital</u>   |  | <b>23d. LOCATION (City, town or county) (State)</b><br><u>Bethesda - Montgomery - Md.</u>  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Mrs. Amelia C. Carter - Administrator - " "</u>   |  | <b>25a. REC'D BY REGISTRAR</b><br><u>APR 12 1967</u>   |  |
| <b>25b. REGISTRAR'S SIGNATURE</b><br><u>J. Charles Judge</u>  |  |  |  |



1  
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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05474

## CERTIFICATE OF DEATH

05472

|  |  |  |  |  |  |  |  |   |  |   |  |
|--|--|--|--|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>Montgomery</i>  |  | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><i>Silver Spring</i> |  | c. LENGTH OF STAY IN ID<br><i>5 yrs 5 months</i>                               |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><i>D.C.</i> |  | b. COUNTY<br><i>Washington</i>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><i>Althea Woodland Nursing Home, 1000 Daleview Dr.</i>   |  |  |  |  |  | d. STREET ADDRESS<br><i>1 Club of Colonial Dames<br/>2110 S. Street, N.W.</i>                                    |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><i>Carrie F. Robinson</i>  |  | 4. DATE OF DEATH<br>Month <i>4</i> - Day <i>7</i> - Year <i>1967</i>                                     |  | 5. SEX<br><i>Female</i>  |  | 6. COLOR OR RACE<br><i>white</i>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><i>12-21-1874</i>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>homemaker</i>  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><i>North Carolina</i>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  | 9. AGE (In years last birthday)<br><i>92</i> yrs.   |  | IF UNDER 1 YEAR<br>Months <i>4</i> Days <i>7</i> Hours <i>19</i> Min.                             |  |
| 13. FATHER'S NAME<br><i>Robert McKnight Furman</i>   |  | 14. MOTHER'S MAIDEN NAME<br><i>Mollie Mathewson</i>  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><i>No</i> |  | 16. SOCIAL SECURITY NO.<br><i>- - -</i>  |  | 17. INFORMANT<br><i>Alexandria, Va.<br/>Miss Evelyn Furman P.O. Box 272</i>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cerebral vascular accident</i><br>DUE TO (b) <i>Generalized arteriosclerosis</i><br>DUE TO (c) <i>#1</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>2 wks</i><br><i>Years</i>                                  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><i>Myocardial infarction</i>  |  |  |  |  |  |  |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)             |  | 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <i>19</i> p.m. <i>19</i>     |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>           |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <i>Jan</i> , 1960, to <i>7 April</i> , 1967, that (I) (we) last saw the deceased alive on <i>2 April</i> , 1967, and that death occurred at <i>1:30 P.M.</i> from the causes and on the date stated above.   |  |  |  |  |  |  |  |   |  |   |  |
| 22a. SIGNATURE<br><i>W. Howard Yeager Jr.</i>  |  |  |  |  |  | 22b. DATE SIGNED<br><i>4/7/67</i>  |  | 22c. PHYSICIAN'S NAME (Type)<br><i>W. Howard Yeager Jr.</i>   |  | 22d. ADDRESS<br><i>1808 Conn Ave. NW, Wash. D.C.</i>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |  | 23b. DATE THEREOF<br><i>4/10/67</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Druid Ridge Cemetery</i>              |  | 23d. LOCATION (City, town or county) (State)<br><i>Baltimore Maryland</i>  |  | 24. FUNERAL DIRECTOR<br><i>Joseph Gawler's Sons</i>   |  | 25a. REC'D BY REGISTRAR<br><i>Charles Judge</i>   |  |
| 25b. REGISTRAR'S SIGNATURE   |  | 25c. REGISTRAR'S SIGNATURE   |  | 25d. REGISTRAR'S SIGNATURE   |  | 25e. REGISTRAR'S SIGNATURE   |  | 25f. REGISTRAR'S SIGNATURE  |  | 25g. REGISTRAR'S SIGNATURE  |  |



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VR A15 (4)  
20 M 1/66

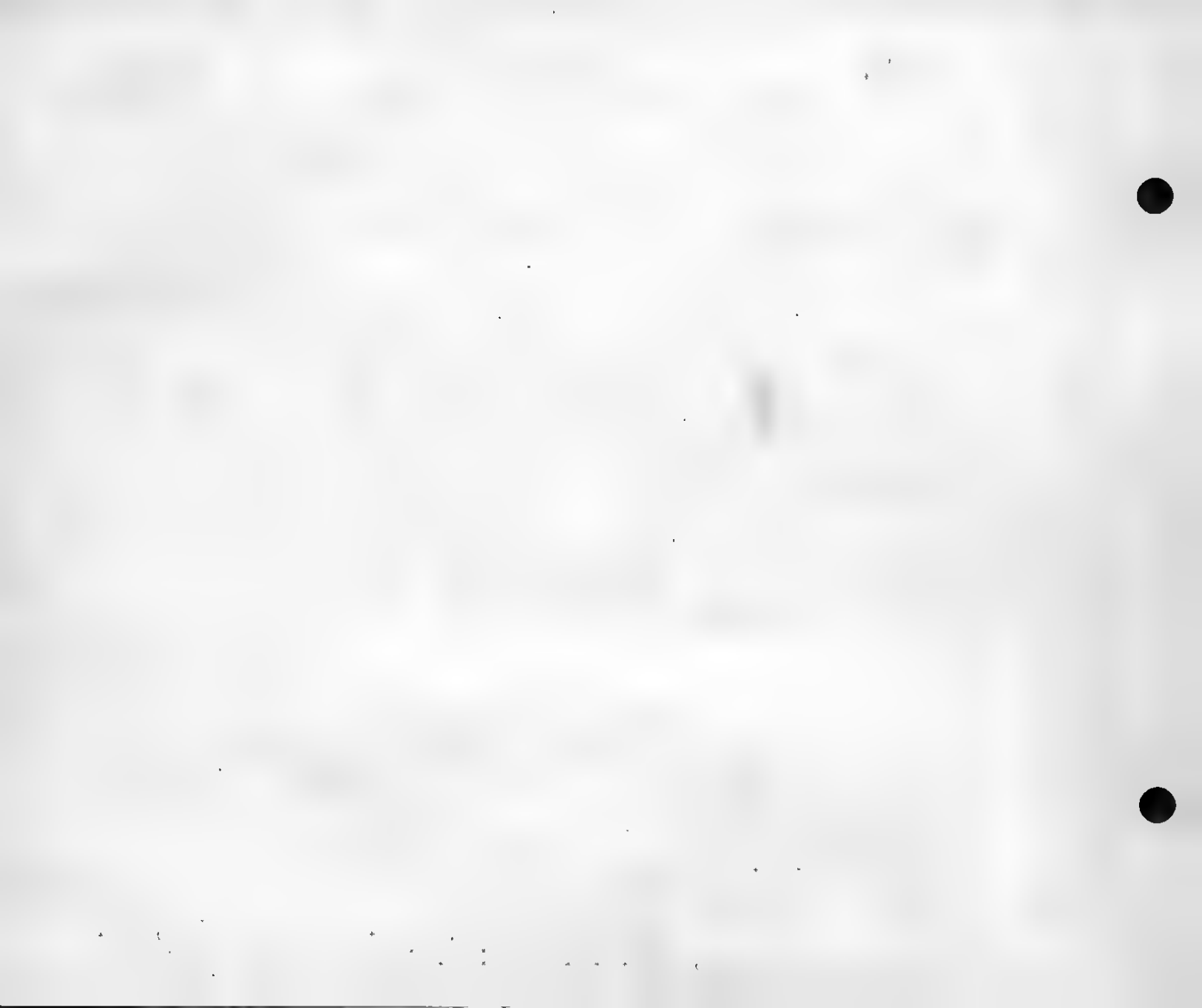
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05475

CERTIFICATE OF DEATH

05473

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>COUNTY <u>Montgomery</u> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Dc</u> b. COUNTY <u>— —</u>                            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Washington D.C.</u> 4.   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Suburban Hospital</u>  |                                  | d. STREET ADDRESS<br><u>4308 Chesapeake St 20016</u>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Angela</u> Middle <u>G.</u> Last <u>Rota</u>  |                                  | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>1</u> Year <u>1967</u>  |  |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Apr 15 1893</u> |
| 9. AGE (In years last birthday) yrs. <u>73</u>  |                                  | IF UNDER 1 YEAR<br>Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>—</u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>—</u>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Italy</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>Italy</u>  |  |
| 13. FATHER'S NAME<br><u>Joseph Dr. Paolis</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Louisa Bompiani</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO<br><u>—</u>  |  |
| 17. INFORMANT<br><u>Carlo Rota-Son</u>  |                                  | Address<br><u>—</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Hemo pericardium</u><br>DUE TO (b) <u>Acute Myocardial Rupture</u><br>DUE TO (c) <u>Acute Myocardial Infarction</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 day.</u><br><u>approx. 2 wks.</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m. <u>—</u>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>March 19 1967</u> to <u>April 1 1967</u> , that (I) <u>last</u> saw the deceased alive on <u>April 1 1967</u> , and that death occurred at <u>10:15 a.m.</u> from causes and on the date stated above.   |                                  |   |  |
| 22a. SIGNATURE<br><u>J. Blaine Fitzgerald</u> M.D.  |                                  | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                              |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Dr. J. Blaine Fitzgerald</u>   |                                  | 22d. ADDRESS<br><u>Bethesda</u>   |  |
| 22b. DATE SIGNED<br><u>4/1/67</u>   |                                  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 23b. DATE THEREOF<br><u>4-4-1967</u>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Gate of Heaven Cem.</u>  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><u>Silver Spring, Md.</u>  |  |
| 24. FUNERAL DIRECTOR<br><u>Joseph Gawler's Sons, Inc.</u>   |                                  | 25a. REC'D BY REGISTRAR<br><u>APR 10 1967</u>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |                                  |   |  |





05476

## CERTIFICATE OF DEATH

05474

|   |  |  |  |
|---|--|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>                      |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Wheaton</u>  |  | c. LENGTH OF STAY IN lb<br><u>6 mos.</u>   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Washington D.C.</u> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Randolph Hills Nursing Home</u>  |  | e. STREET ADDRESS<br><u>3420 16th St. N.W.</u>   |  |
| 3 NAME OF DECEASED<br>(Type or print)<br><u>Jeane L. Rowan</u>  |  | 4. DATE OF DEATH<br>Month <u>April</u> - Day <u>9</u> - Year <u>1967</u>   |  |
| 5 SEX<br><u>Female</u>  | 6 COLOR OR RACE<br><u>White</u>  | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>11-10-86</u>  |
| 9 AGE (In years last birthday)<br><u>80</u> yrs   |  | 10. IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Concert Pianist</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>  </u>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>New York City, NY</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A</u>   |  |
| 13. FATHER'S NAME<br><u>  </u>  |  | 14. MOTHER'S MAIDEN NAME<br><u>  </u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>  </u>   |  | 16. SOCIAL SECURITY NO<br><u>  </u>  |  |
| 17. INFORMANT<br><u>Mr. Roger A. Iello - 725 15th St N.W. Wash DC</u>   |  | Address<br><u>  </u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br><u>332X</u><br>IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u><br>DUE TO (b) <u>Arteriosclerotic Vascular Disease</u><br>DUE TO (c) <u>  </u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 mos</u><br><u>10 yrs</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>Diabetes Mellitus of Insulin</u>   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>  </u>  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>  </u>  | 20f. (City or town) (County) (State)<br><u>  </u>  |
| 21 I certify that (I) (this hospital) attended the deceased from <u>1956, 19</u> to <u>April 9, 1967</u> , that (I) (we) lost saw the deceased alive on <u>March 1967</u> , and that death occurred at <u>9:01 AM</u> , from causes and on the date stated above.   |  |  |  |
| 22a. SIGNATURE<br><u>Marvin Fuchs MD</u>  |  | 22b. DATE SIGNED<br><u>4-9-67</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>MARVIN FUCHS MD</u>  |  | 22d. ADDRESS<br><u>5315 Connecticut Ave DC</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Cremation</u>   | 23b. DATE THEREOF<br><u>4-11-1967</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Hill Cemetery</u>   | 23d. LOCATION (City or town) (County) (State)<br><u>Suitland Md</u>  |
| 24. FUNERAL DIRECTOR<br><u>Joseph Gawler Sons</u>   |  | 25a. REC'D BY REGISTRAR<br><u>APR 14 1967</u>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles George</u>   |  | 25c. ADDRESS<br><u>5130 WISC. AVE N.W. WASH.</u>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

05477

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05475

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. S may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring 3 months</b><br>c. LENGTH OF STAY IN 1b<br><b>3 months</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>2358 Glenmont Circle</b>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Montgomery</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring 15.1</b><br>d. STREET ADDRESS<br><b>2358 Glenmont Circle</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Elizabeth Rowles</b><br>First Middle Last<br><b>Georgia</b>   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>4 30 1967</b>   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>  | 8. AGE (In years, months, and days)<br><b>45 yrs</b>                  |
| 9. AGE (In years, months, and days)<br><b>45 yrs</b>   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Teller</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Pennsylvania</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>George Smoke</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Agnes Krall</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No None</b>   |  | 16. SOCIAL SECURITY NO.<br><b>192-12-8409</b>  |   |
| 17. INFORMANT<br><b>William Rowles</b>   |  | Address<br><b>2358 Glenmont Circle Silver Spring, Md.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Massive aspiration of vomitus</b><br><b>921.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>with asphyxiation</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |  | INTERVAL BETWEEN ONSET AND DEATH                                      |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)<br><b>Deceased vomited &amp; aspirated vomitus</b>   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>1:00 4-30 1967</b>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/><br>of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)<br><b>Home</b>   | 20f. (City or town) (County) (State)<br><b>Silver Spring Montg Md</b> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                    |  |  |   |
| ACTUAL SIGNATURE<br><b>Belden R. Reap</b><br>EXAMINER'S NAME (Type)<br><b>BELDEN R. REAP, M.D.</b>   |  | 22. DATE SIGNED<br><b>4/30/1967</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Trans-burial</b>   |  | 23b. DATE THEREOF<br><b>May 3, 1967</b>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Homewood Cemetery</b>   |  | 23d. LOCATION (City or town) (County) (State)<br><b>Pittsburg, Penna.</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>Warner E. Pumphrey, Inc.</b>  |  | 25a. REC'D BY REGISTRAR<br><b>MAY 4 1967</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |  |   |

15320

03452

05478

## CERTIFICATE OF DEATH

05476

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b>   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Virginia</b>  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (rural)</b>   |   | c. LENGTH OF STAY IN 1b<br><b>76 Days</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Naval Hospital</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Mary Louise Ryan</b>   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>April 29 1967</b>  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>Cauc.</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Oct. 31, 1919</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY   | 9. AGE (In years last birthday)<br><b>47 37 yrs.</b>  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Allston, Mass.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>Herbert F. Dwyer</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary E. Kiley</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO.<br><b>025 18 7819</b>   |   |
| 17. INFORMANT<br><b>Thomas J. Ryan</b>  |   | Address<br><b>916 North Kemper Street Alexandria, Va.</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>LEIOMYOSARCOMA UTERUS WITH WIDE SPREAD METASTASIS</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO<br>(c) _____ |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>NA</b>  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Feb 12</b> , 19 <b>67</b> , to <b>Apr 29</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Apr 29</b> , 19 <b>67</b> , and that death occurred at <b>1:45 AM</b> , from causes and on the date stated above.                                      |   |   |   |
| 22a. SIGNATURE<br><b>R. L. GIBBS MD</b>   |   | 22b. DATE SIGNED<br><b>April 29, 1967</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>R. L. GIBBS MD</b>   |   | 22d. ADDRESS<br><b>Naval Hospital Bethesda, Md.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE THEREOF<br><b>5/3/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Arlington Va.</b>                             |
| 24. FUNERAL ADDRESS<br><b>Everley-Wheatley Funeral Home</b>   |   | 25a. REC'D BY REGISTRAR<br><b>1500 W Braddock Rd Alexandria, Va.</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>James Judge</b>  |   | DATE<br><b>1967</b>   |   |

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